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SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@ifgc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, January 14, 2004
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of November 12, 2003 be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the notes of the Mental Health Board Retreat of December 6, 2003 be approved as submitted.

1.2.c PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the Retreat on December 6, 2003 to the following members: none. Dennis Yun, Sandy Yuen, chance martin.

1.2.d PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 14, 2004, to the following members: Ted Stinson

2.0 PRESENTATION: THE SAN FRANCISCO BUDGET, ED HARRINGTON, CONTROLLER (40 minutes)

2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

3.0 DIRECTORS REPORTS (25 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board

A report including updates and announcements regarding the activities and operations of the Board.

4.0 **MENTAL HEALTH BOARD COMMITTEES** (30 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee. Discussion of budget policy and strategy.

4.1.a PROPOSED ACTION: Be it resolved that the Mental Health Board adopts three issues as its top priorities for 2004: 1) 24/7 Mobile Crisis Services, 2) women and mental health, and 3) the schools and mental health services. (Attachment A)

4.1.b PROPOSED ACTION: Be it resolved that the Mental Health Board takes a position of support for the Substance Abuse Services (Attachment B)

4.1.c PROPOSED ACTION: Be it resolved that the Mental Health Board takes a position of support for the Mental Health Services Act (Attachment C)

Beth Rittenhouse from Mental Health Association will speak briefly about the Act.

4.1.d PROPOSED ACTION: Be it resolved that the Mental Health Board takes a position of support for the CLAS Resolution (Culturally Linguistically Appropriate Standards) (Attachment D)

4.1.e PROPOSED ACTION: Be it resolved that the Mental Health Board will elect new officers at its March Board meeting.

5.0 **NEW BUSINESS** (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 **PUBLIC COMMENT** (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

7.0 **ADJOURNMENT**

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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MENTAL HEALTH BOARD
ATTACHMENT A
January 14, 2004

PROPOSED RESOLUTION (MHB-2004-xx):
MENTAL HEALTH BOARD PRIORITIES FOR 2004

BE IT RESOLVED, that the San Francisco Mental Health Board adopts the following three issues to be its priorities for 2004 in addition to its regular manadated issues such as the mental health budget:

1. Increasing the hours of operation of Mobile Crisis to 24/7.

2. Addressing the needs of women with mental-illness and/or substance abuse issues.

3. Working with the school district to respond better to the needs of students and families dealing with mental illness, substance abuse, or significant emotional distress.

MENTAL HEALTH BOARD
ATTACHMENT B
January 14, 2004

PROPOSED RESOLUTION (MHB-2004-xx):
IN SUPPORT OF SUBSTANCE ABUSE SERVICES

WHEREAS, the Department of Public Health of the City and County of San Francisco is in the process of integrating Community Substance Abuse Services and Community Mental Health Services into Community Behavioral Health Services, and

WHEREAS, integration means meeting the full range of the health needs of public health clients, and designing a system of looking at clients as whole persons rather than collections of symptoms, and

WHEREAS, the Treatment on Demand Planning Council, the Citywide Alcoholism Advisory Board, and the Drug Abuse Advisory Board of the Department of Public Health have stated concerns that across our nation integration has too often meant that substance abuse services become diminished or forgotten, and

WHEREAS, The Report to Congress on the Prevention and Treatment of Co-Occuring Substance Abuse Disorders and Mental Disorders by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, published in November 2002, states in the section titled "Studies of Comprehensive, Integrated Treatment Programs," that although findings of studies done to date are "suggestive rather than conclusive," there are some very positive findings and there is reason for cautious optimism that excellent results can be achieved by integrated programs which assertively address both mental health and substance abuse issues in full measure, instead of focusing on one set of issues while neglecting the other, and

WHEREAS, a significant number of mental health clients either have a history of substance abuse or are at risk of substance abuse, and

WHEREAS, in San Francisco the leading reason why mental health clients who are discharged from the hospital return in short order to the hospital is not their mental illness but substance abuse, and

WHEREAS, the Treatment on Demand Planning Council has expressed serious concerns that the federal government is moving strongly in the direction of looking at alcohol and drug addiction as signs of moral weakness or as a criminal justice issue rather than a public health issue, and

WHEREAS, Kathryn Jett, Director of the California Department of Alcohol and Drug Programs, has stated that it's clear from the work of treatment programs

in California that the most effective to approach to alcohol and drug addiction is to treat these addictions as a public health issue, now therefore

BE IT RESOLVED, that the San Francisco Mental Health Board commends the Department of Public Health for the steps it has taken so far to insure that neither substance abuse services of mental health services will be diminished in the course of integration, but that both groups of services will become stronger and more effective through integration, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the Department of Public Health to maintain vigilance and do everything necessary to make sure that both substance abuse services and mental health services are enhanced rather than diminished, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to continue to respond to alcohol and drug addiction as a public health issue rather than an issue of moral weakness or as a criminal justice issue, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the Department of Public Health to make sure that the voices and needs of both substance abuse clients, mental health clients, and dual diagnosis clients be heard loud and clear throughout the process of integration, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the Treatment on Demand Planning Council, the Citywide Alcoholism Advisory Board, and the Drug Abuse Advisory Board for their vision that in San Francisco the integration of substance abuse and mental health services can be done in an exemplary fashion and can serve as a role model for the nation.

MENTAL HEALTH BOARD
ATTACHMENT C
January 14, 2004

In this attachment you will find the home page of the website for the Mental Health Services Act in case you would like further information, along with a copy of the full text of the Act.

PROPOSED RESOLUTION (MHB-2004-xx):
IN SUPPORT OF THE MENTAL HEALTH SERVICES ACT

WHEREAS, there is an urgent need for additional mental health services for children and adults in the state of California, and

WHEREAS, the Vehicle License Fee (VLF), a source of funding for mental health services, has been cut back by Governor Schwarzenegger, and

WHEREAS, the Mental Health Services Act would create an appropriate funding mechanism for providing needed services through the statewide initiative process, and

WHEREAS, the Board of Supervisors of the City and County of San Francisco has unanimously adopted a resolution put forward by then-Supervisor Gavin Newsom in support of the Mental Health Services Act, now therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board commends and thanks Mayor Gavin Newsom and the Board of Supervisors of the City and County of San Francisco for being the first county Board of Supervisors in the state to support the Mental Health Services Act, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges Mayor Newsom to instruct the Sacramento lobbyist for the City of San Francisco to lobby strongly on behalf of this Act.

FILE NO. 031586 RESOLUTION NO. 638-03

[Urging California Voters to pass the Mental Health Services Act]

Resolution urging the voters of the State of California to pass the Mental Health Services Act.

WHEREAS, Mental illnesses are extremely common, affecting almost every family in San Francisco and people from every age group and background; and

WHEREAS, Failure to provide timely treatment can destroy individuals and families; and

WHEREAS, Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local governments; and

WHEREAS, An estimated 8,500 to 15,000 people in san Francisco are homeless or on the edge of homelessness and approximately 30% of the homeless population has a disabling mental illness; and

WHEREAS, San Francisco with the highest rate of homelessness in the United States, is also likely the United States city with the highest ratio of individuals who are homeless and suffering from disabling mental illness; and

WHEREAS, In a cost cutting move thirty years ago, California drastically cut back its services in state hospitals for people with severe mental illness; and,

WHEREAS, The Board of Supervisors of the City and County of San Francisco believe that California residents with mental illness deserve better service and support; and

WHEREAS, With effective treatment and support, recovery from mental illness is feasible for most individuals; and

WHEREAS, By expanding programs that have demonstrated their effectiveness California can save lives and money; now, therefore, be it

RESOLVED, That the Board of Supervisors of the City and County of San Francisco urges the voters of the State of California to pass the Mental Health Services Act, and enable California to lead the country in providing mental health services to persons currently disabled by mental illness, to persons showing signs of mental illness, and to families and caregivers of those affected.

City and County of San Francisco

Tails

Resolution

City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

File Number: 031586 **Date Passed:**

Resolution urging the voters of the State of California to pass the Mental Health Services Act.

September 23, 2003 Board of Supervisors — ADOPTED

Ayes: 11 - Ammiano, Daly, Dufty, Gonzalez, Hall, Ma, Maxwell, McGoldrick, Newsom, Peskin, Sandoval

File No. 031586

I hereby certify that the foregoing Resolution was ADOPTED on September 23, 2003 by the Board of Supervisors of the City and County of San Francisco.

Gloria L. Young
Clerk of the Board

OCT 03 2003

Date Approved

Mayor Willie L. Brown Jr.

Campaign for Mental Health

A Coalition of Community Mental Health Providers, Concerned Families, and Supporters

Monday, November 03

News

10/06/2003
Mental health care for kids varies widely by state

by Marilyn Elias, USA TODAY

Whether a child gets mental health care depends a great deal on where he lives, according to a study released today. It is the first to examine geographic differences in children's treatment.

A child in Massachusetts is more than twice as likely as a similarly needy child in California to get care, the RAND survey of 45,247 parents shows.

USA Today Link

Full Story

09/22/2003
Proposed mental health initiative battles 30 years of neglect

San Diego City Beat

by Kelly Davis

A year and a few weeks from now, California voters may be given the chance to tax the rich in order to solve the state's mental healthcare problems.

The Mental Health Services Act, as proposed for the November 2004 ballot, would adopt somewhat of a Robin Hood approach to ensure public mental health programs have proper funding. The initiative would levy a 1 percent tax on California residents with a net income, after deductions, in excess of $1 million. Only each dollar earned above $1 million would be taxed. For example, a person earning $1.5 million would be taxed 1 percent of $500,000. Roughly 29,000 Californians—with an average income of $5 million among them—would pay the tax.

SD City Beat web site

Full Story

09/15/2003
Cause of Death: Suicide. Age: 8

People Magazine

Angela Gutierrez's self-inflicted death in the third grade raises a disturbing question: Why are more preteens taking their own lives?

Download this PDF copy of the People Magazine article from 9/15/03.

People magazine Article

Full Story

See Other Recent News Stories

You can contribute: info for 501 (c)(3) orgs.

You Can Contribute: information for 501(c)(3) organizations.

- Clarification of Ballot Measure and Signature Gathring Contributions by 501(C)(3) Nonprofit Agencies.
- Contribution Rules for 501(c)(3) organizations.
- What a 501(c)(3) Organization can do.

Summary

The Mental Health Services Act is a proposed citizen initiative expected to appear on the November 2004 ballot. The initiative expands mental health care programs for children and adults. It provides services to persons currently disabled by mental illness, persons showing signs of mental illness in need of prevention services, and to families and caregivers of those affected. For most adults, the initiative used the recently developed, successful "integrated services" model to link many kinds of care.

The initiative pays for expanded programs through a surcharge on income above $1 million per year. A new 1% surcharge applies to each dollar earned over $1 million. The initiative creates a new oversight and accountability commission to supervise the new mental health care programs.

Please look under "Facts" to learn more about the initiative.

Read the Attorney General's Title and Summary

Read the Full Text

Signature Gathering

If you'd like to help gather Signature to Qualify this Initiative for the ballot, please download and read these documents

- Signature Gathering
- Circulators Affidavit
- Circulator Guidelines
- Circulator Rules

Contribute

If you'd like to contribute to the Campaign, you can either do so online, by designating an amount in the "Contribute" area at the top of the column on the far-right of this page, or if you'd prefer to mail us a contribution, please download the following forms. Contact us directly with any questions. Thanks.

- Contribution Form
- Contribution Rules

Contribute

We need your finanacial support now. Please take a moment to contribute to this campaign.

$25 Go

Endorsements

Board of Supervisors of the City and County of San Francisco
web site

Mental Health Association of Orange County
web site

California Network of Mental Health Clients
web site

Service Employees International Union - California State Council
web site

Congress of California Seniors
web site

Association of Community Human Service Agencies

California Academy of Child and Adolescent Psychiatry
web site

California Alliance of Child and Family Services
Web Site

California Psychological Association
web site

NAMI - California
web site

National Association of Social Workers, California Chapter
web site

Mental Health Association in Los Angeles County
web site

Mental Health Association in California
web site

United Advocates For Children of California
web site

California Council of Community Mental Health Agencies
web site

American Federation of State, county and Municipal Employees, AFL-CIO of California

California Mental Health Planning Council
web site

California Mental Health Directors Association

MENTAL HEALTH SERVICES ACT

SECTION 1. Title

This Act shall be known and may be cited as the "Mental Health Services Act."

SECTION 2. Findings and Declarations

The People of the State of California hereby find and declare all of the following:

(a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.

(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.

(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.

(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

(f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.

(g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars ($1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars ($1,000,000). They have an average pre-tax income of nearly five million dollars ($5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million dollar homes in other states.

SECTION 3. Purpose and Intent.

The People of the State of California hereby declare their purpose and intent in enacting this Act to be as follows:

(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.

(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.

(e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

SECTION 4. Part 3.6 (commencing with Section 5840) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.6 PREVENTION AND EARLY INTERVENTION PROGRAMS

5840. (a) The Department of Mental Health shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.
(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.
(4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:
(1) Suicide.
(2) Incarcerations.
(3) School failure or dropout.
(4) Unemployment.
(5) Prolonged suffering.
(6) Homelessness.
(7) Removal of children from their homes.

(e) In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

5840.2 (a) The department shall contract for the provision of services pursuant to this part with each county mental health program in the manner set forth in Section 5897.

SECTION 5. Article 11 (commencing with Section 5878.1) is added to Chapter 1 of Part 4 of Division 5 of the Welfare and Institutions Code, to read:

Article 11. Services for Children with Severe Mental Illness.

5878.1 (a) It is the intent of this article to establish programs that assure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this Part. It is the intent of this Act that services provided under this Chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.

(b) Nothing in this Act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

5878.2 For purposes of this article, severely mentally ill children means minors under the age of 18 who meet the criteria set forth in subdivision (a) of Section 5600.3.

5878.3 (a) Subject to the availability of funds as determined pursuant to Part 4.5, county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to MediCal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this Part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 of Part 6 of Division 9 (commencing with Section 18250).

(c) The Department of Mental Health shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

SECTION 6. Section 18257 is added to the Welfare and Institutions Code to read as follows:

18257. (a) The Department of Social Services shall seek applicable federal approval to make the maximum number of children being served through such programs eligible for federal financial participation and amend any applicable state regulations to the extent necessary to eliminate any limitations on the numbers of children who can participate in these programs.

(b) Funds from the Mental Health Services Fund shall be made available to the Department of Social Services for technical assistance to counties in establishing and administering projects. Funding shall include reasonable and necessary administrative costs in establishing and administering a project pursuant to this chapter and shall be sufficient to create an incentive for all counties to seek to establish programs pursuant to this chapter.

SECTION 7. Section 5813.5 is added to Part 3 of Division 5 of the Welfare and Institutions Code, to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the Department of Mental Health shall distribute funds for the provision of services under Sections 5801, 5802 and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in Welfare and Institutions Code Section 5600.3(b) and (c). For purposes of this act, seniors means older adult persons identified in Part 3.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this Part with the medically necessary mental health services, medications and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state and federal funds.

(c) Each county mental health programs plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in Section 5600.3(b) and (c).

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section the term grants referred to in Sections 5814 and 5814.5 shall refer to such contracts.

SECTION 8. Part 3.1 is hereby added to Division 5 of the Welfare and Institutions Code commencing with Section 5820 to read:

PART 3.1 EDUCATION AND TRAINING PROGRAM

5820. (a) It is the intent of this Part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the department a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Parts 3, 3.2, 3.6, and 4 of this Division. For purposes of this Part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The department shall identify the total statewide needs for each professional and other occupational category and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The Mental Health Planning Council shall advise the Department of Mental Health on education and training policy development and provide oversight for the department's education and training plan development.

(b) The Department of Mental Health shall work with the California Mental Health Planning Council so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5822. The Department of Mental Health shall include in the five-year plan:

(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.

(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, Masters Degrees, or Doctoral degrees.

(c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.

(d) Establishment of regional partnerships among the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.

(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.

(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Parts 3, 3.2, 3.6, and 4.

(g) Promotion of the employment of mental health consumers and family members in the mental health system.

(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).

(i) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

SECTION 9. Part 3.2 Commencing with Section 5830 is added to Division 5 of the Welfare and Institutions Code to read:

Part 3.2 Innovative Programs

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(a) The innovative programs shall have the following purposes:

(1) To increase access to underserved groups.

(2) To increase the quality of services, including better outcomes.

(3) To promote interagency collaboration.

(4) To increase access to services.

(b) County mental health programs shall receive funds for their innovation programs upon approval by the Mental Health Oversight and Accountability Commission.

SECTION 10. Part 3.7 (commencing with Section 5845) is added to Division 5 of the Welfare and Institutions Code to read:

PART 3.7. OVERSIGHT AND ACCOUNTABILITY

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3, the Adults and Older Adults Systems of Care Act; Part 3.1, Human Resources; Part 3.2, Innovative Programs; Part 3.6, Prevention and Early Intervention Programs; and Part 4, the Children's Mental Health Services Act. The Commission shall replace the advisory committee established pursuant to Section 5814. The Commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county Sheriff, a Superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the Commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the Commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary.

(3) Establish technical advisory committees such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Develop strategies to overcome stigma and accomplish all other objectives of Parts 3.2, 3.6 and the other provisions of the Act establishing this Commission.

(6) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(7) If the Commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the Department of Mental Health pursuant to Section 5655.

5846. (a) The Commission shall annually review and approve each county mental health program for expenditures pursuant to Parts 3.2 for Innovative Programs and Part 3.6 for Prevention and Early Intervention.

(b) The department may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the Commission or when local programs could benefit from technical assistance for improvement of their plans submitted pursuant to Section 5847.

(c) The Commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

5847. Integrated Plans for Prevention, Innovation and System of Care Services.

(a) Each county mental health program shall prepare and submit a three year plan which shall be updated at least annually and approved by the department after review and comment by the Oversight and Accountability Commission. The plan and update shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6.

(2) A program for services to children in accordance with Part 4 to include a program pursuant to Chapter 6 of Part 4 of Division 9 commencing with Section 18250 or provide substantial evidence that it is not feasible to establish a wrap-around program in that county.

(3) A program for services to adults and seniors in accordance with Part 3.

(4) A program for Innovations in accordance with Part 3.2.

(5) A program for technological needs and capital facilities needed to provide services pursuant to Parts 3, 3.6 and 4. All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the Education and Training Programs established pursuant to Part 3.1.

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults and seniors that it is currently serving pursuant to Parts 3 and 4 during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(b) The department's review and approval of the programs specified in paragraphs (1) and (4) shall be limited to ensuring the consistency of such programs with the other portions of the plan and providing review and comment to the Mental Health Services Oversight and Accountability Commission.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (a) shall include services to address the needs of transition age youth ages 16 to 25.

(d) Each year the Department of Mental Health shall inform counties of the amounts of funds available for services to children pursuant to Part 4 and to adults and seniors pursuant to Part 3. Each county mental health program shall prepare expenditure plans pursuant to Parts 3 and 4 and updates to the plans developed pursuant to this Section. Each expenditure update shall indicate the number of children, adults and seniors to be served pursuant to Parts 3 and 4 and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(e) The department shall evaluate each proposed expenditure plan and determine the extent to which each county has the capacity to serve the proposed number of children, adults and seniors pursuant to Parts 3 and 4; the extent to which there is an unmet need to serve that number of children, adults and seniors; and determine the amount of available funds; and provide each county with an allocation from the funds available. The department shall give greater weight for a county or a population which has been significantly underserved for several years.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (6) of subdivision (a) for services pursuant to paragraphs (2) and (3) of subdivision (a) in years in which the allocation of funds for services pursuant to subdivision (c) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

5848. (a) Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of such plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft plan and annual updates at the close of the 30–day comment period required by subsection (a). Each adopted plan and update shall include any substantive written recommendations for revisions. The adopted plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The department shall establish requirements for the content of the plans. The plans shall include reports on the achievement of performance outcomes for services pursuant to Parts 3, 3.6 and 4 funded by the Mental Health Services Fund and established by the department.

(d) Mental health services provided pursuant to Parts 3 and 4 shall be included in the review of program performance by the California Mental Health Planning Council required by Section 5772(c)(2) and in the local mental health board's review and comment on the performance outcome data required by Section 5604.2(a)(7).

Section 11. Section 5771.1 is added to the Welfare and Institutions Code to read:

5771.1 The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the Council is performing its statutory duties pursuant to Section 5772. Such membership shall not affect the composition requirements for the Council specified in Section 5771.

SECTION 12. Section 17043 is added to the Revenue and Taxation Code to read:

17043. (a) For each taxable year beginning on or after January 1, 2005, in addition to any other taxes imposed by this part, an additional tax shall be imposed at the rate of 1% on that portion of a taxpayer's taxable income in excess of one million dollars ($1,000,000).

(b) For purposes of applying Part 10.2 (commencing with Section 18401), the tax imposed under this section shall be treated as if imposed under Section 17041.

(c) The following shall not apply to the tax imposed by this section:

(1) The provisions of Section 17039, relating to the allowance of credits.

(2) The provisions of Section 17041, relating to filing status and recomputation of the income tax brackets.

(3) The provisions of Section 17045, relating to joint returns.

SECTION 13. Section 19602 of the Revenue and Taxation Code is amended to read:

19602. Except for amounts collected or accrued under Sections 17935, 17941, 17948, 19532, and 19561, and revenues deposited pursuant to Section 19602.5, all moneys and remittances received by the Franchise Tax Board as amounts imposed under Part 10 (commencing with Section 17001), and related penalties, additions to tax, and interest imposed under this part, shall be deposited, after clearance of remittances, in the State Treasury and credited to the Personal Income Tax Fund.

SECTION 14. Section 19602.5 is added to the Revenue and Taxation Code to read:

19602.5 (a) There is in the State Treasury the Mental Health Services Fund (MHS Fund). The estimated revenue from the additional tax imposed under Section 17043 for the applicable fiscal year, as determined under subparagraph (B) of paragraph (3) of subdivision (c), shall be deposited to the MHS Fund on a monthly basis, subject to an annual adjustment as described in this section.

(b) (1) Beginning with fiscal year 2004-2005 and for each fiscal year thereafter, the Controller shall deposit on a monthly basis in the MHS Fund an amount equal to the applicable percentage of net personal income tax receipts as defined in paragraph (4).

(2) (A) Except as provided in subparagraph (B), the applicable percentage referred to in paragraph (1) shall be 1.76 percent.

(B) For fiscal year 2004-2005, the applicable percentage shall be 0.70 percent.

(3) Beginning with fiscal year 2006-2007, monthly deposits to the MHS Fund pursuant to this subdivision are subject to suspension pursuant to subdivision (f).

(4) For purposes of this subdivision, "net personal income tax receipts" refers to amounts received by the Franchise Tax Board and the Employment Development Department under the Personal Income Tax Law, as reported by the Franchise Tax Board to the Department of Finance pursuant to law, regulation, procedure, and practice (commonly referred to as the "102 Report") in effect on the effective date of the Act establishing this section.

(c) No later than March 1, 2006, and each March 1st thereafter, the Department of Finance, in consultation with the Franchise Tax Board, shall determine the annual adjustment amount for the following fiscal year.

(1) The "annual adjustment amount" for any fiscal year shall be an amount equal to the amount determined by subtracting the "revenue adjustment amount" for the applicable revenue adjustment fiscal year, as determined by the Franchise Tax Board under paragraph (3), from the "tax liability adjustment amount" for applicable tax liability adjustment tax year, as determined by the Franchise Tax Board under paragraph (2).

(2) (A) (i) The "tax liability adjustment amount" for a tax year is equal to the amount determined by subtracting the estimated tax liability increase from the additional tax imposed under Section 17043 for the applicable year under subparagraph (B) from the amount of the actual tax liability increase from the additional tax imposed under Section 17043 for the applicable tax year, based on the returns filed for that tax year.

(ii) For purposes of the determinations required under this paragraph, actual tax liability increase from the additional tax means the increase in tax liability resulting from the tax of 1% imposed under Section 17043, as reflected on the original returns filed by October 15th of the year after the close of the applicable tax year.

(iii) The applicable tax year referred to in this paragraph means the 12-calendar month taxable year beginning on January 1st of the year that is two (2) years before the beginning of the fiscal year for which an annual adjustment amount is calculated.

(B) (i) The estimated tax liability increase from the additional tax for the following tax years is:

Tax Year	Estimated Tax Liability Increase from the Additional Tax
2005	$ 634 million
2006	$ 672 million
2007	$ 713 million
2008	$ 758 million

(ii) The "estimated tax liability increase from the additional tax" for the tax year beginning in 2009 and each tax year thereafter shall be determined by applying an annual growth rate of seven (7) percent to the "estimated tax liability increase from additional tax" of the immediately preceding tax year.

(3) (A) The "revenue adjustment amount" is equal to the amount determined by subtracting the "estimated revenue from the additional tax" for the applicable fiscal year, as determined under subparagraph (B), from the actual amount transferred for the applicable fiscal year.

(B) (i) The "estimated revenue from the additional tax" for the following applicable fiscal years is:

Applicable Fiscal Year	Estimated Revenue From Additional Tax
2004-05	$ 254 million
2005-06	$ 683 million
2006-07	$ 690 million
2007-08	$ 733 million

(ii) The "estimated revenue from the additional tax" for applicable fiscal year 2007-08 and each applicable fiscal year thereafter shall

be determined by applying an annual growth rate of 7 percent to the "estimated revenue from the additional tax" of the immediately preceding applicable fiscal year.

(iii) The applicable fiscal year referred to in this paragraph means the fiscal year that is two (2) years before the fiscal year for which an annual adjustment amount is calculated.

(d) The Department of Finance shall notify the Legislature and the Controller of the results of the determinations required under subdivision (c) no later than ten (10) business days after the determinations are final.

(e) If the annual adjustment amount for a fiscal year is a positive number, the Controller shall transfer that amount from the General Fund to the MHS Fund on July 1 of that fiscal year.

(f) If the annual adjustment amount for a fiscal year is a negative number, the Controller shall suspend monthly transfers to the MHS Fund for that fiscal year, as otherwise required by paragraph (1) of subdivision (b), until the total amount of suspended deposits for that fiscal year equals the amount of the negative annual adjustment amount for that fiscal year.

SECTION 15. Part 4.5 (commencing with Section 5890) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 4.5. MENTAL HEALTH SERVICES FUND

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The Fund shall be administered by the department of Mental Health. Notwithstanding Section 13340 of the Government Code, all monies in the Fund are continuously appropriated to the Department, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this Division:

(1) Part 3 commencing with Section 5800, the Adult and Older Adult System of Care Act.

(2) Part 3.6 commencing with Section 5840, Prevention and Early Intervention Programs.

(3) Part 4 commencing with Section 5850, the Children's Mental Health Services Act.

(b) Nothing in the establishment of this Fund, nor any other provisions of the Act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this Act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing such obligations of plans and insurance policies.

(c) Nothing in this Act shall be construed to modify or reduce the existing authority or responsibility of the Department of Mental Health.

(d) The Department of Health Services, in consultation with the Department of Mental Health, shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults and seniors for medically necessary care.

(e) Share of costs for services pursuant to Parts 3 and 4 shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless such Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Parts 3 and 4.

5891. The funding established pursuant to this Act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this Act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

5892. (a) In order to promote efficient implementation of this Act allocate the following portions of funds available in the Mental Health Services Fund in 2005-06 and each year thereafter:

(1) In 2005-06, 2006-07, and in 2007-08 10% shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005-06, 2006-07 and in 2007-08 10% for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) 20% for Prevention and Early Intervention Programs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association pursuant to Part 3.6. Each county's allocation of funds shall be distributed only after its annual program for expenditure of such funds has been approved by the Oversight and Accountability Commission established pursuant to Section 5845.

(4) The allocation for Prevention and Early Intervention may be increased in any county which the department determines that such increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase. The statewide allocation for Prevention and Early Intervention may be increased whenever the Oversight and Accountability Commission determines that all counties are receiving all necessary funds for services to severely mentally ill persons and have established prudent reserves and there are additional revenues available in the Fund.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 for the Children's System of Care and Part 3, for the Adult and Older Adult System of Care.

(6) 5% percent of the total funding for each county mental health program for Parts 3, 3.6 and 4 shall be utilized for Innovative Programs pursuant to an approved plan required by Section 5830 and such funds may be distributed by the department only after such programs have been approved by the Oversight and Accountability Commission established pursuant to Section 5845.

(b) In any year after 2007-08, programs for services pursuant to Parts 3 and 4 may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20% of the average amount of funds allocated to that county for the previous five years pursuant to this Section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of such costs shall not exceed 5% of the total of annual revenues received for the Fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Parts 3 and 4.

(d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), the department shall also provide funds for the costs for itself, the Mental Health Planning Council and the Oversight and Accountability Commission to implement all duties pursuant to the programs set forth in this section. Such costs shall not exceed 5% of the total of annual revenues received for the Fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Parts 3, 3.6 and 4.

(e) In 2004-05 funds shall be allocated as follows:

(1) 45% for Education and Training pursuant to Part 3.1.

(2) 45% for Capital Facilities and Technology Needs in the manner specified by paragraph (2) of subdivision (a).

(3) 5% for Local Planning in the manner specified in Subdivision (c) and

(4) 5% for State Implementation in the manner specified in subdivision (d)

(f) Each county shall place all funds received from the state Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on such investments shall be transferred into the Fund. The earnings on investment of these funds shall be available for distribution from the Fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the Fund and available for other counties in future years, provided however, that funds for

capital facilities, technological needs or education and training may be retained for up to ten years before reverting to the Fund.

(i) If there are still additional revenues available in the fund after the Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this Section, including all purposes of the Prevention and Early Intervention Program, the Commission shall develop a plan for expenditures of such revenues to further the purposes of this Act and the Legislature may appropriate such funds for any purpose consistent with the Commission's adopted plan which furthers the purposes of this act.

5893. (a) In any year in which the funds available exceed the amount allocated to counties, such funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) All funds deposited into the Mental Health Services Fund shall be invested in the same manner in which other state funds are invested. The Fund shall be increased by its share of the amount earned on investments.

5894. In the event that Parts 3 or 4 are restructured by legislation signed into law before the adoption of this measure, the funding provided by this measure shall be distributed in accordance with such legislation; provided, however that nothing herein shall be construed to reduce the categories of persons entitled to receive services.

5895. In the event any provisions of Part 3 or Part 4 of this Division are repealed or modified so the purposes of this Act cannot be accomplished, the funds in the Mental Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004.

5897. (a) Notwithstanding any other provision of state law, the Department of Mental Health shall implement the mental health services provided by Parts 3, 3.6 and 4 of this Division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Parts 3, 3.2, 3.6 and 4 of this Division through the annual county mental health services performance contract, as specified in Part 2, Chapter 2, Section 5650 et seq.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific time-line to achieve improvements.

(e) Contracts awarded by the Department of Mental Health, the California Mental Health Planning Council, and the Mental Health Services Oversight and Accountability Commission pursuant to Parts 3, 3.1, 3.2, 3.6, 3.7, 4, and 4.5 may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the department

of the anticipated county matching funds needed for community mental health programs.

5898. The department shall develop regulations, as necessary, for the department or designated local agencies to implement this Act. In 2005, the director may adopt all regulations pursuant to this Act as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 2 of Title 2. For the purpose of the Administrative Procedure Act, the adoption of regulations, in 2005, shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. These regulations shall not be subject to the review and approval of the Office of Administrative Law and shall not be subject to automatic repeal until final regulations take effect. Emergency regulations adopted in accordance with this provision shall not remain in effect for more than a year. The final regulations shall become effective upon filing with the Secretary of State. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

SECTION 16

The provisions of this Act shall become effective January 1 of the year following passage of the Act, and its provisions shall be applied prospectively.

The provisions of this Act are written with the expectation that it will be enacted in November of 2004. In the event that it is approved by the voters at an election other than one which occurs during the 2004-05 fiscal year, the provisions of this act which refer to fiscal year 2005-06 shall be deemed to refer to the first fiscal year which begins after the effective date of this Act and the provisions of this Act which refer to other fiscal years shall refer to the year that is the same number of years after the first fiscal year as that year is in relationship to 2005-06.

SECTION 17

Notwithstanding any other provision of law to the contrary, the department shall begin implementing the provisions of this Act immediately upon its effective date and shall have the authority to immediately make any necessary expenditures and to hire staff for that purpose.

SECTION 18

This Act shall be broadly construed to accomplish its purposes. All of the provisions of this Act may be amended by a 2/3 vote of the Legislature so long as such amendments are consistent with and further the intent of this Act. The Legislature may by majority vote add provisions to clarify procedures and terms including the procedures for the collection of the tax surcharge imposed by Section 16.

SECTION 19

If any provision of this Act is held to be unconstitutional or invalid for any reason, such unconstitutionality or invalidity shall not affect the validity of any other provision.

MENTAL HEALTH BOARD
ATTACHMENT D
January 14, 2004

PROPOSED RESOLUTION (MHB-2004-xx):
IN SUPPORT OF THE CULTURALLY AND LINGUISTICALLY APPROPRIATE STANDARDS (CLAS)

WHEREAS, the population of the United States, in general, and California, in particular, is continuing to increase in its diversity, and

WHEREAS, minority status negatively correlates to health care access and to health care outcomes, and

WHEREAS, the San Francisco Mental Health Board believes that basic health care should be considered to be a fundamental right for all residents of our city, state, and country, and

WHEREAS, the Office of Minority Health (OMH) in the U.S. Department of Health and Human Services (HHS) has developed a set of guiding principals and standards to help local, state, and national agencies provide health care services that are culturally and linguistically appropriate, now therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board gives its full support to the Culturally and Linguistically Appropriate Standards as developed for the Office of Minority Health (OMH) in the U.S. Department of Health and Human Services (HHS), and

BE IT FURTHER RESOLVED, that the Mental Health Board gives its full support and endorsement to the San Francisco Health Commission and the Department of Public Health for their adoption of CLAS as Department policy and for their efforts to implement CLAS, and

BE IT FURTHER RESOLVED, that the Mental Health Board reaffirms its endorsement of the three key focus points of the mental health system in San Francisco, that it be: 1) consumer-guided, 2) community-based, and 3) culturally-competent.

CLAS—CULTURAL AND LINGUISTICALLY APPROPRIATE SERVICES

Guiding Principles
The Health Commission adopted the Culturally and Linguistically Appropriate Services (CLAS) standards as general guidelines in order to provide a uniform framework for developing and monitoring culturally and linguistically appropriate services. In adopting the CLAS Standards the Commission acknowledges that the CLAS Standards as implemented by the Department of Public Health are intended to be broadly inclusive of diverse racial, ethnic, sexual and other cultural and linguistic groups. The CLAS Standards as utilized by the Department of Public Health are intended to serve as general guidelines and not as mandatory requirements.

The following national standards issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

GUIDING PRINCIPLES

Health Care Organizations Should Ensure That Patients/Consumers Receive From All Staff Members Effective, Understandable, and Respectful Care That Is Provided in a Manner Compatible With Their Cultural Health Beliefs and Practices and Preferred Language;

Health Care Organizations Should Implement Strategies To Recruit, Retain, and Promote at All Levels of the Organization a Diverse Staff and Leadership That Are Representative of the Demographic Characteristics of the Service Area;

Health Care Organizations Should Ensure That Staff at All Levels and Across All Disciplines Receive Ongoing Education and Training in Culturally and Linguistically Appropriate Service Delivery;

Health Care Organizations Must Offer and Provide Language Assistance Services, Including Bilingual Staff and Interpreter Services, at No Cost to Each Patient/Consumer With Limited English Proficiency at All Points of Contact, in a Timely Manner During All Hours of Operation;

Health Care Organizations Must Provide to Patients/Consumers in Their Preferred Language Both Verbal Offers and Written Notices Informing Them of Their Right To Receive Language Assistance Services;

Health Care Organizations Must Assure the Competence of Language Assistance Provided to Limited English Proficient Patients/Consumers by Interpreters and Bilingual Staff. Family and Friends Should Not Be Used To Provide Interpretation Services (Except on Request by the Patient/ Consumer);

Health Care Organizations Must Make Available Easily Understood Patient-Related Materials and Post Signage in the Languages of the Commonly Encountered Groups and/or Groups Represented in the Service Area;

Health Care Organizations Should Develop, Implement, and Promote a Written Strategic Plan That Outlines Clear Goals, Policies, Operational Plans, and Management Accountability/Oversight Mechanisms To Provide Culturally and Linguistically Appropriate Services;

Health Care Organizations Should Conduct Initial and Ongoing Organizational Self-Assessments of CLAS-Related Activities and Are Encouraged To Integrate Cultural and Linguistic Competence-Related Measures Into Their Internal Audits, Performance Improvement Programs, Patient Satisfaction Assessments, and Outcomes-Based Evaluations;

Health Care Organizations Should Ensure That Data on the Individual Patient's/Consumer's Race, Ethnicity, and Spoken and Written Language Are Collected in Health Records, Integrated Into the Organization's Management Information Systems, and Periodically Updated;

Health Care Organizations Should Maintain a Current Demographic, Cultural, and Epidemiological Profile of the Community as Well as a Needs Assessment to Accurately Plan for and Implement Services That Respond to the Cultural and Linguistic Characteristics of the Service Area;

Health Care Organizations Should Develop Participatory, Collaborative Partnerships With Communities and Utilize a Variety of Formal and Informal

Mechanisms to Facilitate Community and Patient/ Consumer Involvement in Designing and Implementing CLAS Related Activities;

Health Care Organizations Should Ensure That Conflict and Grievance Resolution Processes Are Culturally and Linguistically Sensitive and Capable of Identifying, Preventing, and Resolving Cross-Cultural Conflicts or Complaints by Patients/Consumers; and,

Health Care Organizations Are Encouraged to Regularly Make Available to the Public Information About Their Progress and Successful Innovations in Implementing the CLAS Standards and To Provide Public Notice in Their Communities About the Availability of This Information.

Non-Discrimination in Provision of Services

Each provider of direct services shall adopt a non-discrimination policy prohibiting on the basis of the fact or perception of race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, height, weight, disability, or AIDS/HIV. The policy shall state whom to contact in instances of possible discrimination.

Each provider of direct services shall make available to clients copies of the non-discrimination policy. In addition, the policy posted in an area visible to clients or at the point of service.

Each provider of direct services shall make available to clients procedures for requesting reasonable accommodation in the receipt of services. In addition, the policy posted in an area visible to clients or at the point of service.

Each provider of direct services shall make available to clients procedures for requesting interpretation services, including American Sign Language, in the receipt of services. In addition, the policy posted in an area visible to clients or at the point of service.

These policies and procedures shall be available in languages and formats (e.g. for persons with disabilities) appropriate to the populations being served.

Grievance Procedures

Each provider of direct services shall provide a fair and expeditious process for the resolution of client grievances.

The policy shall adequately describe the process for resolving client grievances, including identification of whom to contact regarding client grievances and applicable timelines.

The policy shall be available in languages and formats (e.g. for persons with disabilities) appropriate to the populations being served.

Each provider of direct services shall provide an annual report to on the resolution of client grievances.

Cultural and Linguistic Competency Reports

All providers of direct services shall provide an annual Cultural and Linguistic Competency Report. Using the CLAS Standards as general guidance, the Report shall address the provider's ability to provide services to the diverse ethnic, linguistic, sexual or cultural populations served under contract, including: Experience with providing services to the diverse ethnic, linguistic, sexual or cultural population served under the contract; Capacity of staff, including volunteers and Board, to design, provide and evaluate culturally and linguistically appropriate services; providers must include a list of cultural competency trainings that will be conducted in the upcoming year and the methodology that will be used to evaluate these trainings; Specific outcome measures, qualitative and quantitative, that will be used during the upcoming year to assess whether services are culturally and linguistically competent; at least one of the outcome measures must be satisfaction of clients with the services; Description of the provider's process to ensure the involvement of diverse populations, including clients, in the design, provision and evaluation of culturally competent services; Description of collaboration efforts with other programs in the continuum of care which serve culturally and linguistically diverse populations; Identification and proposed remedy of potential barriers that may limit the ability of the provider to provide appropriate services.

Reporting Procedures

All direct service providers shall submit an annual Cultural and Linguistic Competency Report by September 30th of each year, or within 60 days of the award of a contract if the provider has not previously submitted an annual report.

The report shall be submitted to the Department of Public Health Section responsible for monitoring the contract.

A copy of the annual Cultural and Linguistic Competency Report shall be provided to the Department's EEO and Cultural Competency Office.

Requests for Proposals or Qualifications (RFP/Q's)

All Requests for Proposals or Qualifications (RFP/Q's) shall include a requirement that potential contractors demonstrate an ability to provide culturally competent services. Specifically:

Their previous experience with providing services to the diverse ethnic, linguistic, sexual or cultural population to be served;

The current ability of the agency's staff, volunteers, and Board to provide the specific services solicited to the diverse ethnic, linguistic, sexual or cultural population to be served; and

The specific outcome measures, qualitative and quantitative, which demonstrate that the program provides culturally and linguistically competent services.

Program Monitoring

Program Managers/Analysts shall review the cultural and linguistic competency reports utilizing a standardized monitoring protocol as part of their regular contract monitoring process.

The Office of EEO and Cultural Competency, in conjunction with the Cultural Competency Task Force, Program Managers/Analysts, and interested members of the public shall develop a standardized monitoring protocol to ensure that programs are providing culturally and linguistically appropriate services.

Technical Assistance and Training

The Office of EEO and Cultural Competency, in conjunction with the Cultural Competency Task Force, shall offer periodic training activities on cultural and linguistic competency, including population specific and skills based training activities.

The Office of EEO and Cultural Competency shall establish web-based resources to assist contractors and Program Managers/Analysts in the implementation of this policy.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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UNADOPTED MINUTES
Mental Health Board
Wednesday, January 14, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Augusta Del Zotto, Ph.D. (Acting Chair); Bridgett Brown; Bob Douglas, J.D.; Supervisor Bevan Dufty; Carol Knight, M.A.; chance martin; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.; Idell Wilson; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Joel Luebkeman; Ted Stinson (Chair); Kate Walker; Dennis Yun, M.S.W.

BOARD MEMBERS ABSENT: Andrea Leung, L.C.S.W., A.C.S.W.

PRESENTER: Ed Harrington, Controller, City & County of San Francisco

OTHERS PRESENT: LaVaughn King; Bob Cabaj (Director of Community Behavioral Health Services); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR
The meeting was started unofficially at 6:42 p.m. by Augusta Del Zotto, Acting Chair, given that there was not a quorum until later. The Consent Calendar was postponed until after the presentation.

2.0 PRESENTATION BY ED HARRINGTON, CONTROLLER
Mr. Harrington: I'm obviously not here to give you good news. But I can tell you what we know. The last couple days we've been hearing a deficit number of $260 million. We were looking at $160 million problem for the City on its own. Then Governor Schwarzenegger may make cuts of another $100 million.

The motor vehicle tax is the key thing happening at the state level. This was a fairly progressive tax, in that you paid more tax if you owned a more expensive car.
That tax was in place for fifty years with a lot of the money coming to the counties up until 1998. Then in 1998, the State decided to keep all the money, and since then the money has not come back to the counties.

Governor Schwarzenegger repealed the vehicle license fee, but said he will make up for that lost revenue in another way.

We only set aside $30 million for state cuts this year. We also have a reserve fund. But the state cut looks like it will take all the reserve.

Mr. Harrington then handed out the Budget Instructions Overview from the Finance Officers Meeting, December 15, 2003, which included the following:

CURRENT YEAR BUDGET OUTLOOK

The City faces additional possible State losses this fiscal year. These loses would be in addition to the $52 million in State losses suffered to date.

The range of possible losses range from the local impact of the Governor's mid-year reduction proposal ($25 million) to the potential loss of vehicle license fee revenues ($92 million).

Final State decisions on these reductions may not be known for some time, leaving little time to address them at the local level.

STATE CONTINGENCY PLANNING

All General Fund departments should produce a prioritized State budget contingency play by January 16th. Plans should address the possible loss of 7.5% of current year General Fund support.

Given the likely severity of these reductions, savings may be a mix of ongoing and one-time adjustments. Ongoing reductions, if enacted, can be used to meet 2004-05 targets.

Any lay-offs or legislative changes required in these plans should be assumed to be effective April 1st.

The need to implement some or all of these plans should be clearer by the end of January as the backfill funding for vehicle license revenues and the Governor's mid-year cuts are reviewed by the State legislature.

VACANT POSITION ELIMINATION

Budget attrition rates are unacceptably high in many departments. Departments need to eliminate vacant positions and reduce attrition savings rates.

By January 16th, each department should submit vacant position eliminations sufficient to reduce budgeted attrition rates to 6% or lower.

LOCAL BUDGET OUTLOOK

Assuming no additional State losses and current levels of employee take-home pay, the City now faces a $160 million local shortfall for 2004-2005.

Starting balance and reserves	($40M)	
General revenue growth	+ $55M	
Loss of one-time sources	($65M)	
Fixed labor cost increases	($25M)	
Debt, welfare, and other costs	($30M)	
Benefit cost increases	($55M)	
Base Projection	**($160M)**	**Shortfall**

BUDGET UNCERTAINTY

State Budget: The State faces a $10B-$24B shortfall in 2004-05. The range is the result of a number of major unknowns and backfill of Vehicle License Fee revenues. Losses to local government are likely to be significant.

City Retirement Payments: The Retirement Board is currently considering actuarial assumption change that would increase expected contributions rates by as much as $50M from our projections.

PLANNING RANGES FOR 2004-2005

	LOW	**HIGH**
Local budget shortfall	($160M)	($160M)
State budget impact	($50M)	($120M)
Retirement changes	$0M	($50M)
Planning Range	**($210M)**	**($330M)**

INSTRUCTION RECAP

(Due January 16th)
- 7.5% State Contingency Plan
- Unfunded position deletions

(Due February 20th)
- Base budget absorption of citywide benefit costs
- 15% State Contingency Plan

So we are asking departments for a plan to cut 7.5 % cut by this Friday for this year, and a plan for up to a 15% cut next year. We are actually negative right now, and we don't have the legal authority to end the year negative, so we'll have to get back to zero. But then that means next year will be even worse.

The Department of Public Health has a deficit of $13 million right now. But DPH has a billion dollar budget and has capacity to repair their budget more than any other department.

There is a $15 B bond measure on the state ballot in March to pay for operating expenses. That's really a bad idea. But there's not a better one. So we're all for it. There is no other choice.

If the suit to block backfilling the VLF cuts wins and if the $15B bond measure is defeated then the situation will become very serious indeed.

We are thinking that revenues are going to grow by 3-5%. But with the dot-com bust and 9/11, sales taxes dropped thirty percent. It will take us 5-6 years to get back to the level of 2000.

Our airport passengers are down 30% now as compared with 2000. We have lost 65,000 jobs in San Francisco since 2000. This is dismal since the payroll tax is one of our biggest taxes. We have the loss of $65 million in one time changes, which will not be available to us next year.

Virtually all city employees gave up retirement benefits which saved $80M. They took a reduction in pay of 7.5% with no pay increase. All the numbers above assume that this pay reduction will continue next year. If that doesn't work out, all these numbers will get worse.

The pension plan lost $3B in last few years. So we've got to pay more money into our pension plan. That is $44M.

The figures above assume no city worker gets a raise and that there are no COLAs for contractors. That may not be realistic. At some point you have to give people more to keep them going.

So that's our base problem just in San Francisco. Then the state cuts came down..

Supervisor Ma has a working group of people from nonprofits and business, and other places, looking for revenues for next year. You can only put a new tax in place in years when the Board of Supervisors is up for election. It's unclear if that's a possibility. And it could only happen in November. How do you budget in the meantime?

Dr. Del Zotto: Can citizens do anything?

Mr. Harrington: Your state legislators, especially Senator Burton, are very outspoken about how the state cuts are wrong. But unless someone in Sacramento can get it together to raise revenue, or increase a tax, then there is no other solution.

Dr. Del Zotto: How'd we get into this situation?

Mr. Harrington: We had big growth rates in 1999 and 2000. We had state revenue coming in and we spent the money. When you see people in need and you have money, how can you sit on it? One of the things that was passed this past year is a rainy day reserve. When we have growth of 5%, we are required to put some of that away.

So we had growth of expenses because of we had growth of revenue. Then revenue dropped off. But we are not good at cutting. We're now three years into this situation. We can't keep shoring things up.

Even if revenue increases next year, we have this pent up demand from nonprofits and city workers to get paid back for not getting increases for a number of years.

Dr. Moses: With regard to Chris Daly's charter amendment regarding the Health Department, I'm not sure what happened to that. What would be the impact of that if it passed?

Mr. Harrington: It was tabled. Supervisor Daly wanted to protect something that he cared about. But the way it was phrased, it was like the Grinch who stole the budget. It would have taken 40% of the remaining budget and set it aside. The problem with set asides is that you protect some things, but it creates more tension for the things remaining.

We have a $5 billion budget. There is very little discretionary money— perhaps $1.1 B of locally generated money. The Department of Public Health gets $250M of that. Homeless services get $60-100M. There are very few places where we can make decisions to cut.

Dr. Turner: Is it likely that Supervisor Ma's efforts will come to fruition substantially? Are we worse off than other cities?

Mr. Harrington: Supervisor Ma's group is the only game in town. The revenues they are looking at will bring in only $30-40M, which is good, but not enough to fix the $160 M hole. There is still no consensus so far. To date that group is doing a lot of training on how City raises money.

Cities are reasonably well off, because they have much more taxing ability, and the things they support are not the things that are risk in the state budget. Counties are much worse off. Counties are responsible for things like health, but they have very little tax base. In San Francisco we lose on the county side, but do fairly well on the city side.

Ms. Shaffer: What can I do as citizen to help decrease costs and help increase revenue?

Mr. Harrington: Clearly everybody should be trying to protect what they value. The Mayor and Board of Supervisors need to know what you value. The old argument about spending a dollar now will save seven dollars later won't work under present conditions.

Dr. Del Zotto: This presentation was like a well-crafted horror movie, but thank you so much for coming tonight and talking with us.

CONSENT CALENDAR
A quorum was present early in the presentation by Mr. Harrington. So following the end of his presention the Consent Calendar was voted on:

RESOLUTION (MHB-2004-01): Be it resolved that the minutes of the Mental Health Board meeting of November 12, 2003 be approved as submitted. (Passed unanimously.)

RESOLUTION (MHB-2004-02): Be it resolved that the notes of the Mental Health Board Retreat of December 6, 2003 be approved as submitted. (Passed unanimously.)

RESOLUTION (MHB-2004-03): Be it resolved that the Mental Health Board grants leaves of absence for the Retreat on December 6, 2003, to the following members: Dennis Yun, Sandy Yuen, chance martin. (Passed unanimously.)

RESOLUTION (MHB-2004-04): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 14, 2004, to the following members: Ted Stinson, Dennis Yun, Joel Leubkeman. (Passed unanimously.)

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services

Dr. Cabaj: I'd like to introduce Edwin Batongbacal, Assistant Director of Community Behavioral Health Services. He has taken on a lot of the new projects. He may cover for me when I have to be in Sacramento on these second Wednesdays.

To continue discussion of budget, the reality of what Mr. Harrington told us, translates into about $8 million of cuts for CBHS to absorb. We were asked to prepare the 7.5% cut plan, due Friday. It would mean we have to cut services right now. And employees would have to be cut. But the employees gave back 7.5% last year based on having employment for the full year this year.

We will be preparing for 04/05 cuts. One thing Mr. Harrington didn't include in his figures is that costs increase overall and so we need $5 million in CBHS to cover increased costs, without a pay increase and without COLAs.

You all did a tremendous job of advocacy last year with the Health Commission and the Board of Supervisors and almost all of the CBHS cuts were put back into the budget. We're going to need tremendous advocacy this year, too.

As we plan the cuts we're being asked for, we want to follow our plan of last year. We don't want to put a cap on the number of clients. But we are looking at programs that cost a lot and don't treat many people.

We're also losing some state and federal grants in the next year. If we want to backfill those, we will have to cut other services.

As Mr. Harrington also told us, we need to prepare a 15% contingency cut. It seems like that might be more real than ever. Last year we prepared for a possible 10% cut with great anguish. A 15% cut basically decimates the health system.

Last year the Board of Supervisors was tremendous in restoring most of the cuts and recognizing the importance of health services. We revamped and restructured many programs. But most of those strategies won't work a second time in this year.

Director's written report:

Budget Update. The Department is currently preparing its FY04-05 budget. The tasks that each City department must complete include: (1) a FY03-04 7.5% reduction plan (to be used in the event the Mayor can't balance the current year budget due to revenue shortfalls, (2) a FY04-05 5.5% General Fund reduction plan (to address expected FY04-05 shortfalls, and (3) a 15% contingency plan (to be used by the Mayor if the 5.5% plan is insufficient, or if the State budget results in a larger shortfall than is anticipated). The Department will submit the budget to the Health Commission for two reviews in February.

Open House for Maxine Hall Health Center & Westside Methadone Maintenance & Detox Center. Westside Methadone Maintenance and Detox Center, which is co-located with the Maxine Hall Health Center at 1301 Pierce Street, both held their Open House of their newly re-designed offices last December 10. Located in the heart of the Western Addition, people addicted to heroin and opiates can obtain affordable, confidential services from Westside Methadone Treatment Program. A narcotic replacement, methadone is used both as part of a 21 day detoxification process and/or as part of a two year maintenance program.

Approximately 180 individuals a month, predominantly African American adults, are served by this program. The program is designed to gradually reduce the dosage of methadone with the ultimate goal to be drug free. Participants have the opportunity for health and lifestyle changes through vocational and motivational counseling, and referrals for medical treatment and education counseling. The program includes HIV prevention and testing services.

Office Based Opiate Addiction Treatment program (OBOAT). The Office Based Opiate Addiction Treatment program (OBOAT) was initiated in San Francisco in May 2003, culminating a lengthy 4-year planning and development process that included changing federal, state and local legislation and regulations for methadone treatment. OBOAT has received federal funding to initiate a pilot program for 100 patients located

in 4 community settings (two primary care clinics, one private psychiatrist, and one addiction specialist clinic) and the jail. Patients will be treated with methadone or buprenorphine, a medication that received federal approval for office-based practice in October 2002. The OBOAT program allows enrolled patients to receive treatment for opiate addiction within a primary care or addiction specialist setting instead of a traditional methadone clinic. Dosing is conducted at a community-based pharmacy.

This model allows for more comprehensive treatment of patient health issues, for greater preservation of patient privacy, and for increased patient choice in accessing treatment services. Physicians, counselors and pharmacists at the different OBOAT sites are linked through a secure electronic charting database system that allows direct, real-time communication between program providers. The program will enroll 45 patients on buprenorphine, 45 on methadone maintenance, and 10 in methadone stabilization. Over 50 individuals have been evaluated for potential enrollment in the program; current program census is 22: 10 stabilization, 9 methadone and 3 buprenorphine patients. All community sites have initiated services; the jail is expected to begin enrollment in January. The San Francisco OBOAT program is a pilot for the State which allowed initiation of office based programs under SB1807. The State is currently revising Title 9 regulations to include programs like OBOAT, and San Francisco is assisting the State in this process.

Mobile Methadone Treatment Services (Methadone Van). San Francisco initiated mobile methadone treatment in March 2003. Van services were developed with $470,000 in funding over two years from a federal SAMHSA grant for Targeted Capacity Expansion. This combined with additional funding from the Department of Public Health allowed the purchase, outfitting and initial services on two large (Recreational Vehicle size) vans which each have a private dispensing area, wheelchair access, and facilities for urine testing. At full capacity, the van pilot program will serve 150 clients; current census is 42. The van serves clients in two locations each weekday, parking in secure lots in the Mission and Bayview neighborhoods for a two-hour dispensing period. Crisis counseling can be accommodated on board the van, while scheduled counseling appointments are seen in nearby facilities. Van services have been given positive ratings by clients who view the program as extremely efficient and convenient, with skilled and supportive staff. The program is the first of its kind in California, and the State Department of Alcohol and Drug Programs has worked closely with the San Francisco to develop the van as a pilot program for future replication throughout the State. Future goals including qualifying the van and OBOAT programs for MediCal reimbursement.

Cultural Competence Recognition Awards. The following Community Behavioral Health Services mental health programs were selected to receive a Cultural Competence Recognition Award in November 2003: South of Market Mental Health Services, BVHP AB 3632 Program, SAGE, Citywide Case-Management /Forensics, Community Focus, New Leaf, Westside Community Mental Health Services, Instituto Familiar de la Raza, Walden House Adolescent & Adult MHS

Awards were based on the accomplishments made on their 2002-2003 Cultural Competence Objectives. A high ranking was given to those programs who addressed cultural competence at multiple levels - policy/administrative, human resources,

training, evaluation/outcomes and consumer, family and community outreach; and met their objectives with innovation, quality and demonstrated efforts to make institutional impact. This year's award was a paid registration to the State-wide Cultural Competence Summit XI that was held in San Jose, California on November 19 and 20, 2003.

3.2 Mental Health Board Executive Director
You are all invited to attend the Treatment on Demand Planning Council's meeting tomorrow. At 5:30 they will be talking about plans for integration of the work of the advisory boards.

Our MHB Executive Committee has invited the leadership of the Treatment on Demand Planning Council, the Citywide Alcoholism Advisory Committee, and the Drug Abuse Advisory Committee, to meet with them on January 22nd to talk about forming a joint committee of the advisory boards to provide integrated advice to DPH.

One of the officers at the Police Crisis Intervention Training said he's been on the force for 25 years and that this was the best training he's ever gotten.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee

4.1.a Mental Health Board Priorities

RESOLUTION (MHB-2004-05):
MENTAL HEALTH BOARD PRIORITIES FOR 2004

Be it resolved, that the San Francisco Mental Health Board adopts the following three issues to be its priorities for 2004 in addition to its regular mandated issues such as the mental health budget:

1. **Increasing the hours of operation of Mobile Crisis to 24/7.**
2. **Addressing the needs of women with mental-illness and/or substance abuse issues.**
3. **Working with the school district to respond better to the needs of students and families dealing with mental illness, substance abuse, or significant emotional distress. (Passed unanimously.)**

4.1.b In support of Substance Abuse Services

RESOLUTION (MHB-2004-06):
IN SUPPORT OF SUBSTANCE ABUSE SERVICES

WHEREAS, the Department of Public Health of the City and County of San Francisco is in the process of integrating Community Substance Abuse Services

and Community Mental Health Services into Community Behavioral Health Services, and

WHEREAS, integration means meeting the full range of the health needs of public health clients, and designing a system of looking at clients as whole persons rather than collections of symptoms, and

WHEREAS, the Treatment on Demand Planning Council, the Citywide Alcoholism Advisory Board, and the Drug Abuse Advisory Board of the Department of Public Health have stated concerns that across our nation integration has too often meant that substance abuse services become diminished or forgotten, and

WHEREAS, The Report to Congress on the Prevention and Treatment of Co-Occuring Substance Abuse Disorders and Mental Disorders by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, published in November 2002, states in the section titled "Studies of Comprehensive, Integrated Treatment Programs," that although findings of studies done to date are "suggestive rather than conclusive," there are some very positive findings and there is reason for cautious optimism that excellent results can be achieved by integrated programs which assertively address both mental health and substance abuse issues in full measure, instead of focusing on one set of issues while neglecting the other, and

WHEREAS, a significant number of mental health clients either have a history of substance abuse or are at risk of substance abuse, and

WHEREAS, in San Francisco the leading reason why mental health clients who are discharged from the hospital return in short order to the hospital is not their mental illness but substance abuse, and

WHEREAS, the Treatment on Demand Planning Council has expressed serious concerns that the federal government is moving strongly in the direction of looking at alcohol and drug addiction as signs of moral weakness or as a criminal justice issue rather than a public health issue, and

WHEREAS, Kathryn Jett, Director of the California Department of Alcohol and Drug Programs, has stated that it's clear from the work of treatment programs in California that the most effective to approach to alcohol and drug addiction is to treat these addictions as a public health issue, now therefore

BE IT RESOLVED, that the San Francisco Mental Health Board commends the Department of Public Health for the steps it has taken so far to insure that neither substance abuse services or mental health services will be diminished in the course of integration, but that both groups of services will become stronger and more effective through integration, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the Department of Public Health to maintain vigilance and do everything necessary to

make sure that both substance abuse services and mental health services are enhanced rather than diminished, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to continue to respond to alcohol and drug addiction as a public health issue rather than an issue of moral weakness or as a criminal justice issue, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the Department of Public Health to make sure that the voices and needs of both substance abuse clients, mental health clients, and dual diagnosis clients be heard loud and clear throughout the process of integration, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the Treatment on Demand Planning Council, the Citywide Alcoholism Advisory Board, and the Drug Abuse Advisory Board for their vision that in San Francisco the integration of substance abuse and mental health services can be done in an exemplary fashion and can serve as a role model for the nation.
(Passed unanimously.)

4.1.c Mental Health Services Act
Beth Rittenhouse: I'm the Program Director for the Mental Health Association in San Francisco (415-241-2926). We are leading the effort to pass the Mental Health Services Act in San Francisco. This statewide initiative has been put together by the California Mental Health Coalition, which is a broad coalition of mental health stakeholders, including trade unions, police, and education organizations.

In San Francisco we want to organize volunteers to collect 20,000 signatures. Statewide we need 550,000. We're also using paid signature collectors. Someone asked about what citizens could do about the budget. Here's something you can do.

This Act would raise $600 million for comprehensive mental health services based on the wrap around model, like the one used by the MOST Team in San Francisco. It would provide these services for children, adults, and seniors.

How do we pay for it? There would be a surcharge on individual incomes over $1 million, a surcharge of one penny on the dollar for every dollar over $1 million. This would generate $600 million. The Act is polling very well. Two thirds of the people hearing the arguments pro and con are in support, and that includes people with incomes over $1 million. The main opposition is coming from people in the income range of $200,000 to $900,000.

The San Francisco Board of Supervisors has endorsed this Act. All major mental health organizations are supporting it. There is not a lot of organized opposition.

RESOLUTION (MHB-2004-07):
IN SUPPORT OF THE MENTAL HEALTH SERVICES ACT

WHEREAS, there is an urgent need for additional mental health services for children and adults in the state of California, and

WHEREAS, the Vehicle License Fee (VLF), a source of funding for mental health services, has been cut by Governor Schwarzenegger, and

WHEREAS, the Mental Health Services Act would create an appropriate funding mechanism for providing needed services through the statewide initiative process, and

WHEREAS, the Board of Supervisors of the City and County of San Francisco has unanimously adopted a resolution put forward by then-Supervisor Gavin Newsom in support of the Mental Health Services Act, now therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board commends and thanks Mayor Gavin Newsom and the Board of Supervisors of the City and County of San Francisco for being the first county Board of Supervisors in the state to support the Mental Health Services Act, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges Mayor Newsom to instruct the Sacramento lobbyist for the City of San Francisco to lobby strongly on behalf of this Act. (Passed unanimously.)

4.1.d Culturally and Linguistically Appropriate Standards

RESOLUTION (MHB-2004-08):
IN SUPPORT OF THE CULTURALLY AND LINGUISTICALLY APPROPRIATE STANDARDS (CLAS)

WHEREAS, the population of the United States, in general, and California, in particular, is continuing to increase in its diversity, and

WHEREAS, minority status negatively correlates to health care access and to health care outcomes, and

WHEREAS, the San Francisco Mental Health Board believes that basic health care should be considered to be a fundamental right for all residents of our city, state, and country, and

WHEREAS, the Office of Minority Health (OMH) in the U.S. Department of Health and Human Services (HHS) has developed a set of guiding principals and standards to help local, state, and national agencies provide health care services that are culturally and linguistically appropriate, now therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board gives its full support to the Culturally and Linguistically Appropriate Standards as developed for the Office of Minority Health (OMH) in the U.S. Department of Health and Human Services (HHS), and

BE IT FURTHER RESOLVED, that the Mental Health Board gives its full support and endorsement to the San Francisco Health Commission and the Department of Public Health for their adoption of CLAS as Department policy and for their efforts to implement CLAS, and

BE IT FURTHER RESOLVED, that the Mental Health Board reaffirms its endorsement of the three key focus points of the mental health system in San Francisco, that it be: 1) consumer-guided, 2) community-based, and 3) culturally-competent. (Passed unanimously.)

4.1.e Mental Health Board Elections

RESOLUTION (MHB-2004-09)
Be it resolved that the Mental Health Board will elect officers at its March Board meeting. (Passed unanimously.)

Ms. Shaffer: In accord with MHB priority #3, Board members will go to a special meeting of Board of Education on January 20th on Special Education. Carol and I are preparing presentations for that night.

5.0 NEW BUSINESS

Dr. Moses: We have two new elected officials. I would like us to send them congratulations, let them know about our priorities, and invite them to our meetings.

Dr. Turner: To kick off the priorities, it would help to have educational presentations for the Board at our meetings.

6.0 PUBLIC COMMENTS
none.

7.0 ADJOURNMENT
There being no further business, the meeting was adjourned at 8:25 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, February 11, 2004
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of January 14, 2004 be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 11, 2004, to the following members: Bridgett Brown

2.0 PRESENTATION: Supported Housing in the System of Care and Budget Advocacy (45 minutes)

Steve Fields, Executive Director, Progress Foundation

2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

3.0 DIRECTORS REPORTS (25 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
~~The Chair will report discussions and actions of Executive Committee.~~
Discussion of budget policy and strategy.

4.1.a Report of the Nominating Committee on the slate of officers nominated for 2004-2005.

4.1.b PROPOSED ACTION: Be it resolved that the congratulation letters to Mayor Gavin Newsom and District Attorney Kamala Harris be approved as submitted.

4.1.c PROPOSED ACTION: Be it resolved that the Mental Health Board establish a Behavioral Health Integrated Advisory Committee with members of the Treatment on Demand Council, with each Board designating three members to meet on a regular basis to collaborate on issues concerning integration of mental health and substance abuse services.

4.1.d Discussion of programs to visit and Board goals for these visits.

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

7.0 ADJOURNMENT

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI

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3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

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MENTAL HEALTH BOARD
ATTACHMENT A
February 11, 2004

PROPOSED RESOLUTION (MHB-2004-xx) **Be it resolved that the Mental Health Board sends a letter of congratulations to Mayor Gavin Newsom and District Attorney Kamala Harris.**

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February 11, 2004

The Honorable Gavin Newsom
Mayor of San Francisco
City Hall, Room 200
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Dear Mayor Newsom,

On behalf of the San Francisco Mental Health Board, congratulations on your election to be the 42nd Mayor of San Francisco.

We appreciate the time you have taken to meet with us in the past and your willingness to engage in the complexities of San Francisco's mental health issues. In recognition of your work, at our January 14th meeting, the Mental Health Board passed a resolution thanking and commending you for taking the lead in support of the Mental Health Services Act. We are proud that San Francisco was the first county in California to endorse the Act.

As we begin 2004, we'd like to take the opportunity to applaud Community Behavioral Health Services (formerly Community Mental Health Services and Substance Abuse) for their achievements in 2003. Under the new leadership of Dr. Robert Cabaj, Community Behavioral Health Services has continued their effort to do more with less, increasing the quality and availability of services while focusing on good fiscal management and efficiency.

Among the initiatives worth mentioning are the "Any Door, the Right Door" and Advanced Access programs. "Any Door, the Right Door" connects San Franciscans who walk into any public health facility with the right mental health or substance abuse services. Advanced Access dramatically streamlines the waiting times at each step in the request, evaluation and treatment cycle. These are but two of the smart ideas that team has put in place; we'd encourage you to contact Dr. Cabaj and his staff for additional information.

Looking ahead to 2004 and beyond, we share your view that San Francisco can do much better for the mentally ill people on our streets. The Mental Health Board intends to redouble is work on this and related issues in the coming year, tackling such areas as outreach, supportive housing, vocational training, behavioral health courts and involuntary outpatient treatment.

In addition to ongoing work on the issues above, each year the Mental Health Board designates several areas as annual priorities. For 2004, the Mental Health Board chose the following three areas:

1. Increasing the operation of the Mobile Crisis Treatment Team to 24 hours a day, seven days a week.

2. Raising the visibility women's mental health and substance abuse.

3. Improving mental health and substance abuse services at San Francisco Unified School District.

In summary, while we believe progress has been made with mental health issues in San Francisco, much work remains. Towards that end, the Mental Health Board requests the opportunity to meet with you and further discuss these and other important issues. We will follow up with your staff to arrange a time convenient for you.

Sincerely,

Ted Stinson
Chair
Mental Health Board

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February 11, 2004

The Honorable Kamala Harris
District Attorney
Hall of Justice
850 Bryant Street
San Francisco, CA 94103

Dear Ms. Harris,

The San Francisco Mental Health Board sends its congratulations to you on being elected District Attorney for San Francisco.

We look forward to working with you in developing strategies for responding to the needs of the large number of mentally-ill people who have become part of the criminal justice system. We invite you to make use of the expert staff within Community Behavioral Health Services to provide you with information and strategies regarding these needs, and we will be glad to help you connect with them if you like.

At its meeting on November 12, 2003, the Mental Health Board passed a resolution in support of the Behavioral Health Court. A copy of our resolution is enclosed.

The Board has followed the development of the Behavioral Health Court which held its first cases on January 8, 2003. That evening, Judge Harold Kahn presented the design of the court to the Board. Judge Susan Breall gave us an update in September of 2003. The Court provides the opportunity for persons with mental illness to enter treatment rather than jail. As you know the number of mentally-ill people among the jail population is estimated to be 30 to 40%, and recidivism is high without treatment.

For your information, the Mental Health Board established three priorities for the year. One of the priorities is increasing the hours of the Mobile Crisis Treatment Team to 24/7. We are also encouraging a 24/7 drop-in center for the mentally ill. Another priority is women's mental health, and the final priority is facilitating more collaboration between the school district and community mental health services.

So again, congratulations! We look forward to working with you.

Sincerely,

Ted Stinson
Chair

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UNADOPTED MINUTES
Mental Health Board
Wednesday, February 11, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bob Douglas, J.D.; Carol Knight, M.A.; Andrea Leung, L.C.S.W., A.C.S.W.; Joel Luebkeman; chance martin; Toye Moses, Ph.D., M.P.H.; Kate Walker; Idell Wilson; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Bridgett Brown; Augusta Del Zotto, Ph.D.; Supervisor Bevan Dufty; Dorothy Shaffer, R.N., N.P., M.S.N.; Dennis Yun, M.S.W.; Rebecca Turner, Ph.D.

BOARD MEMBERS ABSENT: none

PRESENTER: Steve Fields, Executive Director, Progress Foundation

OTHERS PRESENT: Bob Cabaj (Director of Community Behavioral Health Services); LaVaughn King; Ruth Jackson (Polly's Family Support Center); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR
The meeting was started unofficially at 6:40 p.m. by Ted Stinson, Chair. A quorum was not present until 7:00 p.m. The Consent Calendar was postponed until after the presentation.

2.0 PRESENTATION : Supported Housing in the System of Care and Budget Advocacy—Steve Fields, Executive Director, Progress Foundation

Mr. Stinson: I first met Steve at the Mental Health Board reception several years ago, and was impressed. He's a tireless advocate for mental health services.

Mr. Fields: Tonight I'm going to be talking about the role of supported housing in the system of care, and what the budget implications are for services given the current budget uncertainty.

Let me give you some quick background first. I've been with Progress Foundation since 1969. I was the first counselor in the first halfway house. We just had a group of clients and me.

The Mental Health Board is one of my affinity groups, given the diversity of people on the Board. You're not just people with professional training, but you have a whole wide range of experiences and opinions. Mental health treatment is not just a science of medicine. It's way too complicated for that. If mental illness was only a biochemical problem, someone would have to explain to me why African Americans are only 8% of the population but 40% of the clients in the Emergency Room.

There are a whole lot of factors involved in mental illness, including poverty and racism. Unless we address those issues, we will never get ahead.

I got into this work as an English student. This was during the Vietnam War era, and I had planned to go to prison. I had planned to refuse induction into the armed services. I just happened to get Conscientious Objector status. As part of that I had to do alternative service. Progress had opened, but didn't have any staff, so I got the job. My first credential was I would work for free.

I never took psychology in college. I had learned everything I knew about mental illness from the media, from shows like Hawaii 5-0.

Then I started working with six women with serious issues. They had things to teach me and I had things to teach them. This has been the foundation of Progress since we started.

I come from a very specific bias. Progress Foundation is committed to preventing institutional treatment and to challenging why we put people in institutions, locked facilities, and state hospitals.

I called what we did in 1969 rehabilitation and recovery. I thought our system was too quick to diagnose people. A doctor might give you one diagnosis today and another different diagnosis six months later. Or two doctors on the same day might give you very different diagnoses. And one of my clients was on massive doses of psychiatric medicine, and it was killing her.

So I come to this conversation with the feeling that we need to approach this issue with a sense of urgency and a sense of humility. It was 15 years into my career when the consumer movement started.

One of my pet peeves is when people say something is accepted wisdom. For example saying that the reason we have so many homeless mentally ill on the streets is that we closed the state hospitals back in the 70's and the dollars didn't follow the patients.

Ronald Reagan did a good thing in closing the state hospital. He screwed the mentally ill when he was president.

What we did wrong was we didn't have a conception of what a community mental

health system should look like separate from the institutions. And what should it look like in each locale, San Francisco vs. Chicago.

It was the courts and the legislature, not the mental health leaders who supported the Short Doyle legislation for mental health services. The mental health directors voted against Short Doyle.

The state took the state hospital and unbundled it. What they forgot is they didn't have containment anymore. Once a client was in the community they had the choice not to engage in treatment. If meds made you impotent you might well choose hallucinations over impotence.

Professionals diagnosed it as treatment resistance and we looked for more ways to control people.

If they were going to start a new county in California and they said to me, Steve, get a mental health system ready for this new county, I would say, "You're going to start with affordable housing that is in safe, dispersed sites around the community, not in one ghetto, or one hotel.

Then you're going to have flexible vocational services so people who can only work one day a week, they can. Or if they can work 40 hours, they have that option. And if they hit a rough patch they can drop back down for a while.

Progress has been doing supported housing since 1971. The term is new, but the concept is old. We had a case management team who could go out to work with people.

It's probably true in that kind of system some people will not manage to do well. That's when you open your first 24-hour beds. And then you get to your first hospital bed, because you've tried everything else.

Most states still have a majority of their patients in state hospitals. New York is just starting to de-institutionalize. So when people talk about New York having solved its mental health issues, that a specious argument.

In San Francisco we do the opposite, we open hospitals first then step down to skilled nursing facilities, and then step down again. Not a surprise that housing was not part of the mental health lexicon until Jo Ruffin became director.

Baker Places has had co-ops since 1968. Supported housing has always been in our system. It's only recently that policy people have come to recognize it and support it.

We have a mental health culture that is fond of developing new models. But the problems are so complex, that we need to look at what kind of mental health system we want to create. What are the values? I was on a panel of the President's Commission on Mental Health. Right up to the last minute they were not going to look at the long-term mentally-ill.

As a part of preparing for being on that panel I read the literature. What was the thinking? Where did we go wrong? Well, there wasn't any thinking.

I saw so much patronizing—the attitude that we know what's best for you. That attitude permeates the mental health system. Does that mean every clinician? No. Does it mean every program? No. But still it's a dominant theme.

Treatment resistance is another term indicative of that attitude. We diagnose that. Women did not want to go to the South of Market Clinic with men walking around yelling and being scary. So they were diagnosed with resistance to treatment.

It might have even been true sometimes that we know what's best for people, but can't make them do it. The system kept tying to figure out ways to control people. So we're not always in agreement with the family movement, but I admire them as one of first groups of consumers to stand up for themselves. My heart is really with the consumer movement and has been since it first started in California.

Supported housing ought to be the first thing we do. The problem is that mental health systems don't pay enough attention to why people end up in the institutions.

Progress has four acute diversion programs. We were the first in the country to divert people out of the ER and into a residence. And the risks we took—if I knew then what we know now I wouldn't have done it.

But I had to stop the flow into hospital, because those long term stays just create persistency of the problems.

San Francisco deserves credit for coming to me and asking me to start more acute diversion programs.

A pet peeve I have about the mental health system is that it's stopped believing in relationships. In the assessment of clients we ask: What brought you into the system? What was the episode? What were the things you were grappling with? The single most often checked box is loneliness. That's why in our residential treatment programs there is no time frame on when we talk with clients. If a client is up at 2 a.m., a counselor is there for them.

One key thing we're treating is isolation. What happens for people in the mental health system, is that your context peels away and you end up isolated and lonely.

Much of the mental health system was individual treatment. Recovery is a social progress. You learn in relationship to other people. You test new skills. That process is central to recovery.

The idea of a continuum of care is to find alternatives. Acute diversion or crisis residential programs are there to reduce and minimize the use of institutional treatment.

We have a wide range of 24-hour residential treatment programs. All are designed to minimize the use of the hospital and skilled nursing facilities.

In terms of co-op apartments, we master lease 18 apartments. Baker Places has 40. We support clients based on individual contracts. We meet with them once a week. We meet with the household to help with processing issues when necessary. The apartments are scattered across the city. Some clients like this arrangement so much they stay six, eight, even ten years in co-ops. Some stay a shorter time.

Residential treatment is not the same as supportive housing. It's supportive, but it's also treatment. The co-ops are the first level of supportive housing.

We have crisis housing, transitional housing, co-op apartments, and then permanent housing, usually in large sites, like hotels, and the clients can accept or reject specific programming and support.

Progress was the first to get a grant to build a residential program through HUD. We built our first apartment building for HUD in 1990, with eleven units. We have two town houses. We just broke ground for 15 units for family housing at La Playa, where Playland at Beach used to be. One adult in the family has to have mental illness for the family to be eligible.

The condo owners in the neighborhood did not believe our building belonged there. The same was true with the Clay Street House in Pacific Heights. We chose that site specifically to have that fight.

If we only do our housing in the South of Market and Tenderloin, there is indeed lots of housing stock, but it doesn't meet my vision of moving into other neighborhoods throughout city, and we end up creating our own ghetto.

San Francisco General Hospital runs its own hotel program in the Tenderloin. But it refers people there too soon, when they are not ready.

Seventy percent of our clients are people being diverted from the hospitals. If there are no beds in the hospitals, they will divert people you can't believe they are diverting. Eight times out of 10 they are suicidal.

The hospital has to stay full economically. But if Mitch Katz gave me two of the units at SFGH I could have them empty in two days. Are they first looking for something else to do, before putting someone in the hospital? Barbara Garcia believes in that concept. Liz Gray believes in it. I think Mitch believes in it, but moving these large systems like SFGH is hard.

If we eventually wean ourselves from inpatient treatment, then over time we will need less residential treatment. We want to prevent the necessity of going into the ER room as a ticket into housing.

With addiction we understand that 24 hour services for 6-8 months minimally is necessary. No one believes you should put someone with an addiction in a hotel with

their drug connection right around the corner. People need time and support before moving on.

Think about the mentally ill. San Francisco has come to say. If you've got one problem, and it is substance abuse, you go into residential program for six months or more. But if you have both problems, substance abuse and mental illness, you only get 3-4 months, then you're sent to a hotel.

That's not a clinical decision; that's a resource decision.

In the mid 80's residential treatment used to be a one-year program. Alan Leavitt, the director of mental health at that time said we need twice as many programs, or we should cut the program time in half and open up beds that way. I understood the math of cutting the program time, but it was not a good clinical decision. We had to work twice as fast.

Staff ask me, Why are we moving people out when they are just getting it together? Diminished resources is just a reality. But that reality needs to be understood in the context of what the clients need.

We have a 90% success rate of anyone getting into our co-ops and staying there. Baker Places has the same success rate.

I'm grateful the Mayor has discovered supported housing. He's talking about it like it's a new intervention. But it's not.

The most important piece of making supportive housing work is recognizing the other levels of treatment needed.

There are all kind of dangers if supported housing is not done right. There needs to be standards. One of my biggest concerns is about naive, inexperienced services. SFGH is opening hotel rooms on the cheap, moving people into hotel rooms with only case management and medications, and this will blow it up in their face. They went into supported housing without talking to Progress Foundation and Baker Places.

One of things that happened in CBHS, at Mitch Katz's instigation, was the patient flow project, bringing this office into patient flow more than ever before. CBHS is now involved in deciding who is ready to leave hospital. They've brought down the unpaid acute number of clients. They put Liz Gray in charge, and now the movement of clients out of the hospital when they don't need to be there is greater.

In terms of advocacy and the budget, I want to let you know about the Human Services Network, which is a coalition of 100 nonprofits that offer health and human services in San Francisco. Prior to 1998 there was no organized voice. There was a balkanization of services.

I started the mental health contractors association. I tried to get people organized. Trying to get contractors and nonprofits to get political is very hard. Tom Ammiano got involved in a situation at the AIDS Foundation proposing to have the boards of

nonprofits elected by the community. In reaction, 50 nonprofits ended up getting together to fight this proposal.

The service system by necessity is switching from clinics run by the City and County to the private nonprofit sector. The City can't afford the cost of civil service staff. Starting with the AIDs/HIV epidemic, the nonprofit system for delivering services has become the priority. Substance abuse services is almost all contractors. The same is true for HIV services, and mental health services are increasingly so.

The Human Services Network is now a standard required stop for any supervisor. They know they need to come there. For the first time, mayoral candidates Susan Leal and Gavin Newsom specifically reached out to this group

You are invited to join us. We would like to have the voice of the MHB in that room.

Budget advocacy has shifted. Agencies still do their own advocacy for their own programs as usual, but this past year the HSN was a huge force in the budget process. We met with Supervisors Daly and Peskin, and turned out people to testify.

The HSN has been having conversations with the unions. I'm union. Progress has been union for many years. The argument needs to be treatment oriented. If the unions are fighting to hold on to institutional beds simply to hold on to jobs, then that's not progress. Unions see their next market is in the nonprofits, because there's not that much growth in the City and County civil service positions. But if the unions are not treatment oriented then don't ask us to join.

In 2002, the HSN had its first rally and turned out hundreds of people. SEIU donated the sound system.

A year later, Josie Mooney, the most adept, skillful, politically-connected union rep in the city, and I went jointly to seven supervisors who have strong labor ties. We said don't cut staff whether they're union or not. Supervisor Peskin was surprised to see us together. We're not trying to save our jobs at the expense of other programs.

We've met with businesses downtown, we've met with the Committee on Jobs. We want this to be more than the classic sectarian fight—downtown vs. services.

I would recommend that one of the ways you channel budget advocacy is to be involved in the HSN. Let us know what other things you might be doing so that we can support you. The tough thing this year are the unknowns about the new Mayor, and the overwhelming $260 million projected deficit depending on what happens at the state level.

Mitch Katz was supposed to present the first draft of cuts. But Mayor Newsom called that off and called Mitch in to talk with him. I think this is a good sign. The Mayor can't afford these cuts while he's trying to solve the homeless problem. His political career is dependent on visibly solving the problem of homelessness. He isn't going to continue his career unless he is able to achieve some success.

I think he is going to look for solutions and not just budget cuts to bail him out.

Ms. Walker: When do you have your meetings?

Mr. Fields: The Human Services Network meets on the 3rd Friday of the month at Progress Foundation at 368 Fell Street, between Gough and Octavia. The meetings start at 9:30 a.m. and go until 11:30 a.m. or so. For more information you can call Debbie Lerman at 668-0444.

Ms. Leung: I worked with hospital acute units the last ten years. I did see progress as far as discharging patients, but the challenge is higher and higher. I could relate to most of what you shared as far as moving patients from the ER to ADUs directly. But that only happens at SF General, not in the private hospitals. I have to disagree with you, because most hospitals I've worked at really didn't want to have a full house for some reason.

When I was doing discharge, I wanted to get people out as soon as possible, because utilization review was tough. But it was difficult to get patients out, because 70% of ADU beds are restricted to patients from PES.

Mr. Fields: You're right to make a differentiation. The private hospitals and SF General are two different systems. I think the thing you guys know better than anyone is that our resources aren't adequate. But still there are things we should be doing differently. Forty ADU beds are not enough. We've got people backing up, waiting for a place to go.

We've not had a single net new residential bed since 1998. In the past 16 years, we probably have had a net loss of beds. The only sector we expanded in that time was supportive housing, but not enough to take the pressure off.

It's amazing that our system is still working. That's a sign of how hard everyone is working.

We have ignored vocational services to our detriment. People think its for the highest functioning clients. But that's not true. There should be vocational services at all levels.

Mr. Douglas: Do your people work with the State Department of Rehabilitation?

Mr. Fields: No, they don't. We're like ships passing in night. The Department of Rehabilitation has a hard time understanding vocational rehab for people with mental illness.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services

Dr. Cabaj: We don't have a budget to address yet. Mayor Newsom actually came in person to the Health Commission last Thursday. I think it's historic. I can't remember a mayor doing that. He said he wanted to understand each and every cut. This is a landmark. I think it's a good sign.

He recognized that DPH often will offer cuts no one will approve. He will obviously have to do some cuts. But he wants to look at creative ways to make the cuts to limit the negative effects.

Mitch Katz was meeting with the Mayor again this afternoon.

The next meeting of the Health Commission is February 17th, but we are not sure if the cuts will be presented then. What's nice is that the Mayor wants to be involved right away, rather than the old pattern.

There may be an additional Health Commission meeting in March. The March 2nd meeting is supposed to be an update on behavioral health integration. But this may be delayed by the budget.

We have been spending hours working on budget issues, then re-working and re-working the numbers.

Mr. Stinson: What is the philosophy you're following as you look at the cuts?

Dr. Cabaj: One of our top priorities is not to cut the number of people we're serving, though the form in which we serve them may change. We want to preserve residential care as much as possible.

Substance Abuse Services is almost 100% dependent on General Fund moneys, so their programs are very vulnerable. We're still one of the richest counties. We're trying to do something creative to keep as many services as we can but there may be a change in the modality. For example, last year we cut day treatment programs.

The Mayor is a big advocate of substance abuse services as well as mental health services.

Mr. Douglas: Does the Mayor see services as part of the answer to homelessness.

Dr. Cabaj: I think he's taking the approach that the answer to homelessness is supported housing but not so much treatment. His target group, the hard core homeless, definitely have substance abuse and mental health issues. Supported housing alone will not break that cycle. We hope he will appreciate the fact that we need more outreach services. Would like to advocate for more programs like AB 2034, which is the MOST Team's special outreach to the homeless mentally ill. I think that's the ideal model, and it hardly ever gets talked about. It would help if we could find ways to advocate for that.

This Mayor listens, and he reads everything. Whatever you send him, he'll read it.

The Director's written report was distributed.

Budget Update. The Department presented a partial version of the FY04-05 budget to the Health Commission on February 5, 2004. As a result of Mayor Newsom's request for additional time to review the proposed contract agency reductions with the Department, these reductions were not presented. Instead, the Department presented

structural issues, revenue enhancements and cost saving measures. The Department will have two more budget hearings where the budget reduction proposals will be considered by the Health Commission. The next scheduled Health Commission meeting is on February 17th. It is not known at this time if the budget reduction proposals will be discussed at this time.

Alternatives Program. The State Department of Mental Health awarded CBHS a two year grant to develop alternatives to Institutions for Mental Disease (IMDs, i.e., locked psychiatric facilities) for African American men. In an IMD study conducted in 2002 by the Quality Management section of CBHS, it was found that African American men were disproportionately represented in IMDs, had longer lengths of stay, and returned at a higher rate to institutional care after discharge. This grant, which was awarded beginning July of 2003, provided resources to develop an intensive case management team with some limited resources for housing, vocational and wrap-around services. The program is to serve at least 40 clients within the two year period. Thus far, 10 clients have been admitted into the program; 5 of these clients are now living in the community and 5 are preparing for discharge from IMDs.

The program is trying to develop a culturally competent approach to working with clients in order to improve the rate of successful return to the community. While the caseload is still small, staff observe that the clients discharged from IMDs require daily assistance, have expressed spiritual needs, and need practical education regarding how to survive in the community. Finding appropriate housing to meet their needs is a continuous challenge. The CBHS Placement Team and the Housing and Urban Health Office have been actively supportive of the Alternative Program's efforts. Many of the clients eligible for this program have long histories (years) of treatment in IMDs and many have been involved with the criminal justice system. An independent evaluator contracted by the State has just finalized evaluation surveys to be completed by clients and staff every six months.

3.2 Mental Health Board Executive Director
Ms. Brooke: I want to thank Rich Snowdon for managing all MHB issues while I was gone on vacation.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee

CONSENT CALENDAR

RESOLUTION (MHB-2004-10): Be it resolved that the minutes of the Mental Health Board meeting of January 14, 2003, be approved as submitted. (Passed unanimously.)

RESOLUTION (MHB-2004-11): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 11, 2004, to the following members: Bridgett Brown, Augusta Del Zotto, Dorothy Shaffer, Dennis Yun. (Passed unanimously.)

Report of the Nominating Committee
Mr. Leubkeman: The Committee is nominating the following slate of officers:

Chair - Ted Stinson
Vice Chair - Augusta Del Zotto
Secretary - Carol Knight

Mr. Stinson: We will be holding the election at our March meeting. I encourage you to put your name forward if you'd like to run for one of these offices. Nominations from the floor will be taken at time of the election.

Ms. Walker: How was the Nominating Committee chosen?
Mr. Stinson: It was chosen by the Executive Committee.
Ms. Walker: I read that you have by-laws both for the Mental Health Board and San Francisco Mental Health Education Funds.
Ms. Brooke: I'll be glad to send you a copy of both sets of bylaws.

RESOLUTION (MHB-2004-12) Be it resolved that the Mental Health Board send a letter of congratulations to Mayor Gavin Newsom and District Attorney Kamala Harris.

4.1.c Behavioral Health Integrated Advisory Committee
Mr. Stinson: We have been asked by Barbara Garcia to find a way we can have alignment with the substance abuse advisory boards and work with them in an integrated way, just as mental health and substance abuse services are being integrated into Community Behavioral Health Services.

The Executive Committee is proposing to create the Behavioral Health Integrated Advisory Committee. No one is talking about discontinuing the Mental Health Board. We are a state-mandated board and will continue as long as the state mandates it. But it is important for the advisory boards to work better together.

I'd like to ask which Board members are interested in working on this.

Board members who volunteered: Kate Walker, chance martin, Carol Knight.

There has been tension between substance abuse services and mental health services. This has arisen from miscommunication and fear about the future. I strongly encourage you to think about them and us as being on the same team. There is significant value from us working toward a common cause instead of thinking of us as being in opposition in any way.

RESOLUTION (MHB-2004-13) Be it resolved that the Mental Health Board establish a Behavioral Health Integrated Advisory Committee with members of the Treatment on Demand Council, with each Board designating three members to meet on a regular basis to collaborate on issues concerning integration of mental health and substance abuse services. (Passed unanimously.)

4.1.d. The discussion of programs to visit was postponed until a later meeting.

5.0 NEW BUSINESS
mr. martin: I would like an update on Jail Psych Services. There has been some controversy, and certainly they've been weathering some less than favorable things about jail psych services. Since they are the largest provider of mental health services, we should stay abreast of what they are doing.

Ms. Walker: I want to second that.

Ms. Leung: I will be leaving the Mental Health Board and stepping down as Chair of San Franciso Mental Health Education Funds. I actually feel bad about leaving. This has been a very good experience the last four years. Helynna and Rich are just so impressive as far as making all the meetings work and keeping us up to date. This has really been a great experience for me. I've been starting my own private practice and am really busy, and have been missing quite a few meetings the last 6-7 months so it seems like time to let go, even though I don't really want to.

6.0 PUBLIC COMMENTS
Mr. Kalman: I would like you to officially ask Recreation and Park to present a report on how many programs they have responding to their ADA requirements, including programs for people with mental illness. I think it's very important that there be such programs.

7.0 ADJOURNMENT
There being no further business, the meeting was adjourned at 8:30 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, March 10, 2004
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of February 11, 2004 be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of March 10, 2004, to the following members: Bridgett Brown

2.0 ELECT OFFICERS FOR 2004 (10 minutes)

The Nominating Committee selected Ted Stinson, Chair, Augusta del Zotto, Co-Chair, and Carol Knight, Secretary. Nominations can be made from the floor.

2.1 PROPOSED ACTION: Election of Officers.

3.0 PRESENTATION: PARENTS AND YOUTH SHARE THEIR EXPERIENCE (35 minutes)

Pat Mejia, Director of Support for Families with Disabled Children, along with parents and youth, will share their experience regarding mental health services in the school district.

3.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

4.0 DIRECTORS REPORTS (25 minutes)
For discussion.

4.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

4.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

5.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

5.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee. Discussion of budget policy and strategy.

5.1.b Report of the Program and Services and Children's Committee: Discussion of programs to visit, Board goals for these visits, Revised questionnaires.

6.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

7.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

8.0 ADJOURNMENT

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
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UNADOPTED MINUTES
Mental Health Board
Wednesday, March 10, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Ted Stinson (Chair); Augusta Del Zotto, Ph.D.; Bob Douglas, J.D.; Carol Knight, M.A.; Joel Luebkeman; chance martin; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.; Kate Walker; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Bridgett Brown; S upervisor Bevan Dufty; Toye Moses, Ph.D., M.P.H.; Idell Wilson.

BOARD MEMBERS ABSENT: Dennis Yun, M.S.W.

PRESENTERS:
Pat Mejia, Program Director, Support for Families of Children with Disabilities
Maria, Parent
Erica, Parent
Galina Yudovich, Lowell High School

OTHERS PRESENT: Bob Cabaj (Director of Community Behavioral Health Services); Stacey Blankenbaker (San Francisco Unified School District); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:45 p.m. by Augusta Del Zotto, Acting Chair

CONSENT CALENDAR

RESOLUTION (MHB-2004-14): Be it resolved that the minutes of the Mental Health Board meeting of February 11, 2004 be approved as submitted. (Passed unanimously.)

RESOLUTION (MHB-2004-15): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of March 10, 2004, to the following members: Bridgett Brown, Toye Moses, Idell Wilson. (Passed unanimously.)

ELECTION
Ms. Walker asked to abstain from voting for officers.

RESOLUTION (MHB-2004-16): Be it resolved that the Mental Health Board allows Kate Walker to abstain from voting for officers of the Board. (Passed unanimously.)

The following were elected officers for two year terms. All Board members voted in favor, with the exception of Kate Walker abstaining:

Ted Stinson - Chair
Augusta Del Zotto - Vice Chair
Carol Knight - Secretary

3.0 PRESENTATION : Special Education
Ms. Mejia: Support for Families with Disabilities is a grassroots organization that has been in existence for 21 years. It was started by two parents who were also professionals. They wanted to do something to break the isolation of parents. This is a parent -driven organization. Families have to want our services. We offer a huge range of services.

We have a phone line staffed by parents of children with disabilities. Our parents represent a range of disabilities. In terms of language capability, we have English, Spanish, Mandarin, Cantonese, Tagalog, and American Sign Language.

We have about 15 different groups, a drop-in library, and a newsletter. We do an enormous amount of training in the community. We offer monthly workshops.

All our services are free of charge to families and professionals. We get 1400-1600 calls a month, about 50% of them from professionals looking for more resources. We have a social worker on staff who provides short-term counseling and case management. We provide family links to mental health.

Mr. Luebkeman: Are the seminars limited to San Francisco residents?
Ms. Mejia: No, we're funded for San Francisco, but anyone can come to our groups. But out-of-county residents don't get the same amount of follow up.

We have an Annual Resource Conference coming up. The behavior workshops have filled up already. I'm also a parent. I have a 17-year old daughter with multiple disabilities and a behavior problem.

I've handed out a report we wrote on "Special Education Services in the San Francisco Unified School District." This was originally submitted to the Board of Education a couple months ago.

What we find over and over is that school staff don't understand disabilities and our kids become the bad kids. We need disability awareness training all the way through the district.

One service we run is Open Gate. We have a collaboration kids project. We do it from acivil rights perspective. We have kids come in and talk about what it's like to have disabilities. It's wonderful work.

We would like the system to provide training district wide. We want to build the capacity of all teachers. There is a need for teacher training. We want to allow staff to have access to expertise.

My child was "Miss Congeniality" for years, but then all of a sudden there were behavior problems. Two weeks later her teacher said my daughter couldn't be in her class anymore. And she had had my daughter for three years. I know it was fear, but it was also that she didn't understand her responsibilities. Her attitude was, "I'm a teacher, I don't have to deal with behavioral issues." It's important for teachers to know the law and have training.

For some kids, behavioral intervention is needed, but not mental health services, but they are referred to mental health services. We need to get information to teachers and principals about behavioral staff at the district.

Families need more information about the law, like IDEA (Individuals with Disabilities Act). And they need it to be given to them over and over, because things change for families.

We want to build the capacity of students with disabilities to be successful. We want to build the capacity to ensure success of children with behavior issues. These are tough issues. It's a relatively new concept to provide behavioral intervention rather than punitive intervention. We should have training be mandatory for all staff. Anyone who will have contact with the child should know what it means to make a behavioral intervention.

We want to build the capacity to serve diverse populations. I was able to diagnose my child before going to the doctor. Families that don't speak English find it difficult to get information. Families that don't speak English go to IEP meetings and the forms are already filled out and they are just asked to sign. Or if there are interpreters they are often not professionals. There is a need for cultural competency within the assessment staff.

We want to partner with School District, so that staff and parents are getting training together. There are situations where teachers are denying service, but they are not being malicious. They just don't have the information and don't know what the law says. Sometimes the parent knows more about the law than the professional does.

Some school personnel do not think about mental illness as a disability. Perhaps we need to establish an ombudsman role, and that person should be an outside employee, not employed by the school district or mental health.

Mr. Luebkeman: What's an example of a positive behavioral intervention? When children begin acting out, are there generally different diagnoses for kids 6 years old and 13?

Ms. Mejia: The Hughes bill requires responding to behavioral outbursts in a positive way rather than in a punitive way. The idea is to create a positive behavioral health plan. The focus is not on looking at what's wrong with the child, but looking at everything going on in the child's life.

For example, my daughter has ADD and cerebral palsy. There were times when she would just pop out of her seat in the classroom. The staff wrote a behavioral plan not identifying her as a problem.

Nina needed to have breaks and it worked for her to choose when she needed them. She knew when her body hurt, when she was in pain. She had a card she pulled out which had three options on what she could do, and she'd pick one. Her behavioral problems diminished almost immediately, and it was a very simple solution. With regard to diagnoses, it really depends on the child.

Dr. Turner: With these diagnoses around behavioral issues, it does take into account the developmental level of the child, so there are different diagnoses for a child who is 6 as opposed to a 16-year-old. It's hard to separate out all the factors and to know the causality, because the factors interact with each other.

Ms. Brooke: Sai-Ling Chan-Sew, Director of the Children, Youth and Family Section of CBHS, fully intended to be here, but was just called to a special meeting with Mitch Katz about the budget. Dorothy Shaffer and I met with Arlene Ackerman at a house party. I want to thank her for sending Stacey Blankenbaker to our meeting as her representative.

Dr. Del Zotto: It seems to me one of the key problems is to promote information on parents rights and how the IEP (Individual Education Plan) process works. It could be as simple as just producing a pamphlet and making sure all parents have it. Is there something we could do?

Ms. Mejia: It's actually super complicated because of the law. We do trainings once a month. We collaborate with the schools when families are being assessed. The families get a packet of information about our organization.

Dr. Del Zotto : What about families who are not yet connected and don't even know about any of their rights? Ms. Mejia: We do a lot of outreach with hospitals and community groups, but it's very difficult.

Dr. Turner: I would think the schools would want to get connected with you because it would make their lives so much easier. Do you find that to be the case?

Ms. Mejia: We've had that in the past. But when administrations change the relationship can change. For all the issues around Superintendent Rojas, he was very open to us and open to providing trainings to teachers. When a new administration comes in the door can close.

Dr. Turner: What's the situation currently?

Ms. Mejia: We're really trying. Last year the SELPA Director was Diana Blackman, and she was really great. Ralph Scott is the new director and we're hoping he will stay open to us.

I'd now like to introduce Maria, who is a parent. She came to us about her younger son, who has autism. But her older child is getting services through the schools.

Maria (speaking in Spanish with Ms. Mejia translating): I have two children and my 9 year old is receiving mental health services. Roberto has ADD, and the process worked for him very quickly because his teacher was involved.

One thing the teacher wanted to do right way was to get medication started. The school director was encouraging us to use medications. Right now Roberto is taking a medication and we've seen an improvement. he's one of the top five students in the class now. He's been studying his multiplication tables and has been able to memorize them, and was able to pass the test. One thing that really helps the kids to help motivate them, is when there is a partnership between the school, the parent, the teachers, and the student.

Mr. Luebkeman: How do you feel about your son taking medication? Were you reticent at first? What helped you become comfortable?

Maria: At first I was reticent, because it was ironic that the older one who was "normal" was the one who was getting medication, but my autistic son didn't take medication.

For a while my husband and I had to go back and forth on the whole medication question. We experimented. We did medication just on school days but not on the weekend. We saw a big difference when he was off the medication. He had difficulty concentrating. When he went back on the medication his grades when up, and he was improving at school.

Mr. Douglas: Did the mental health or school people try to force medication?
Maria: At the beginning, I did feel under pressure, but in hindsight, it was the right thing to do after all, because we've seen improvement.

Ms. Knight: Has there been any talk about tapering your older son off medication and working with professionals on behavior?
Maria: Yes, they are considering it. Right now he's on the lowest dose possible of his medication. He doesn't use it on weekends and we're planning not to use it for summer vacation. Eventually we'll be tapering it off, but not anytime soon.

Mr. Stinson: Part of the reason to invite members of the community in to talk with us is our concern about the responsiveness of school administrators or teachers. Any thoughts about whether the schools could have done a better job?

Maria: There weren't any problems at first. But there are no bilingual services. My husband speaks English very well, so it works out, but many families don't speak English.

Ms. Del Zotto: We've asked Galina to talk with us about mental health needs and services at the high school level.

Ms. Yudovich: I'm a junior at Lowell High School. In 2002, a junior, Thomas Hu, took his own life with a gun in the basement of his parent's home. He was the captain of the football team, he was on the wrestling team, and was a track star of my school. He was a top student at Lowell, which is a hard school.

Despite all his success he felt he wasn't the best. His football coach was my teacher at the time. I was told that he didn't think he was good enough. He never did as well as he thought he should. Those pressures are present for every teen in the county.

The issue of mental health is one that gets overlooked, Mental health is a footnote, not a priority, but it's a pressing issue. My school has a Wellness Center, but not that many students use it. Not every student who needs it, uses it. I don't know why.

There are a lot of pressures and stresses present in the lives of teens. It's frightening. Suicide could happen again. One thing that stands out is how unprepared everyone is for this kind of situation. The staff is not trained to deal with tragedy. It's not an every day thing. It's not a top priority. Teachers didn't know what to do. Counselors are on site, but they have to deal with transcripts and academic counseling.

Mr. Stinson: In your perspective, based on what you know about your classmates, do you think it's a question of awareness about the existence of the Wellness Center or discomfort with accessing services because of stigma or fear?

Ms. Yudovich: It's not lack of awareness. Everyone knows what it is and where it is. I don't think it's fear of using it. We are working to bridge the gap that mental health is a taboo topic. I don't get that feeling or vibe, that kids aren't using it because they're afraid. It might be because they don't think the services can help them.

Dr. Turner: What do you think would be helpful to the school system in terms of services or consultants?

Ms. Yudovich: An idea would be to have a representative from each grade from each school working with the District and the MHB to communicate what's going on. Stress can be a huge factor in one school, or gangs in another school. We can't just have one uniform approach to all schools.

In terms of bringing people in when there is a crisis, one problem is that you have to talk with someone who you don't know and they didn't go through the experience with you. We have to put a lot on the line to go and talk with someone about our friend dying.

Ms. Shaffer: I'm really glad Galina could come talk with us about this. There are children every day thinking about suicide as an option because of the stress they're under.

Ms. Blankenbaker: I work with high school Wellness Centers. Galina raised a good issue about the differences between schools. There are sites where the Wellness programs are overbooked and there is a waiting list for services. I think stress and depression at Lowell are the highest priority needs. At other schools, it's gang violence or pregnancy issues. Stress can manifest itself differently at different schools. I would want to hear any ideas about increasing the use of the Wellness Centers.

Ms. Yudovich: I seek out help from my friends, rather than the Wellness Center. I depend on talking with friends. A friend of mine died on an Urban Pioneers trip. My friends and I talk with each other but then we don't have professional training.

Dr. Del Zotto: We also have Erica with us tonight. She's a parent of a child with a disability.

Erica: I was crying earlier because of the question you asked about how the District could be there more for people. I feel the District wasn't there for my son. I have a 14 year old with a disability. My crying is a mixture of joy and anger and different emotions. The lack of services early on caused my son to be in a residential center in Utah now, and I miss him terribly.

I feel the District really failed me, and failed my son, even though they are now having to pay a higher price as far as money is concerned. My son is improving and making changes, but I wish he was at home with me making these changes instead of being far away.

I feel the District continues to ignore children's educational needs and my son's needs were never met and they turned into mental health issues.

My three small children miss my son. We miss him terribly. I just wish that no other parent ever has to go through this. It's very hard when you are asking for services, and sometimes your communication is blocked. My health was affected from me having to fight so hard for what the law said my son was entitled to receive. It took an attorney to get what my son deserved, because everyone kept turning away from it. I had to get an outside lawyer. Everyone knows my name in the School District, because I wasn't going to take no for an answer.

School staff would just take my son out of the classroom and isolate him. I'm glad I came tonight. I want to be able to support other parents. I wish the problems could go away and parents could get the services they need for the kids without having to jeopardize their own health and mental health.

Ms. Shaffer: What could have made the difference? Erica: I wish they could have done a reassessment and not just look at my son's problems as a behavior issue. They had the doctor's reports about his ADD, dyslexia, and auditory processing difficulty. But he was labeled as lazy. They said he didn't want to work. And that I was babying him too much. The report validated what I was telling them.

Dr. Del Zotto: Thanks for coming here. I know it took a lot and thanks for being such an advocate for your son.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services

Dr. Cabaj: I know the budget is on everyone's mind, and basically what I can say, is that we still don't have one. The Health Commission will officially review the cuts on March 16th, and at a second special hearing on March 23rd. The official material will be available Friday through the DPH website: www.sfdph.org

I don't know what will be there. The Mayor has shown extraordinary interest. He has done a whole different approach from the last mayor. He's gone over everything line by line and practically knows it by heart. He's trying to create a budget that is realistic and balanced. He's a true advocate of behavioral health care. So he's trying to minimize the impact. But still there will be huge cuts.

If we look at our budget, the section most dependent on the general fund is substance abuse services. So the cuts in this area might be disproportionate. But the Mayor is particularly interested in substance abuse programs. I wish I had more information to give you.

With regard to the Wellness and Recovery model, clients love it. Many who were resistant to the idea of being in groups in place of individual therapy, now don't want to go back to individual. Our hope is that we will expand these Wellness programs throughout the city.

Mr. Stinson: What about step-down or diversion? Dr. Cabaj: You can come in at any stage. It's not quite preventive services, but early intervention services. The emphasis is on peer-run programs, but if the clients need more they can get into more intense programs.

Ms. Knight: If a family member wanted their loved one in these programs who should they call? Dr. Cabaj: You can call the Access number, 415-255-3737. Or you can call the Hyde Street program directly. Tina Yee and Edwin Batongbacal can help you with that.

Ms. Shaffer: What about youth? Dr. Cabaj: There is more evidence now on how you can identify mental illness earlier and earlier, but the State is proposing cuts that are going to diminish youth services, including eliminating the children's system of care.

Mr. Kalman: I have a business card from the General Manager of the Recreation and Park Department. Rec and Park has a mission to provide services to people with disabilities. I would like to see them provide recreation for the mentally ill.

You just mentioned the Wellness and Recovery centers. We all know the benefit of recreational therapy. Also Rec and Park gets lots of federal and state grants which obligate them to satisfy all the ADA requirements. Can something be done? I don't have to explain about how you feel after a day in nature in social groups.

Dr. Cabaj: We don't have a direct working relationship with the Rec and Parks Department, but we do have lots of activities in our programs. We have a gym in the

Mental Health Rehabilitation Facility. The Wellness Center has lots of activities including getting out of the Center to go walking. Working directly with Rec and Parks is pretty much individual to the clinics.

The Directors written Report was distributed:

Budget Update. The Public Health Department's Budget Hearings for 2004-05 will be presented to the Health Commission on Tuesday, March 16 and Tuesday, March 23. Health Commission meetings begin at 3 p.m., 101 Grove St., Room 300.

Cultural Exchange Program. The South of Market Mental Health Center has been asked for a second year to participate in an educational cross-cultural exchange sponsored by Stanford University for 30 Japanese medical students in their 3rd and 4th year of residency. It is scheduled for March 22, 2004 in the afternoon. Their aim is to expose the participants to cross-cultural issues in health care and to explore differences in medical care between Japan and American in particular. The South of Market Mental Health Center was selected to represent a community based mental health clinic serving an inner city population and for its specialty programs serving the Filipino community and homeless mentally ill population. Dr. Steven Wozniak, MD and Carey Martin, Nurse Practitioner will be hosting the site visit.

Wellness and Recovery Centers—Peer Component. As part of our Dual Diagnosis SAMHSA grant, CBHS is placing peer support interns and funding peer activities at four outpatient clinics and one consumer-run self help center. The peers, consumers of mental health and substance abuse services, are part of CBHSs efforts to implement Wellness and Recovery Centers at the following mental health outpatient clinics:

Chinatown Northbeach Mental Health Services
Sunset Mental Health Services
Hyde Street Recovery Center
Bayview Intensive Case Management Program

Spiritmenders, a program of the San Francisco Client Network, makes up the fifth program, which is completely consumer-run.

Each program has been given the flexibility to design their peer component activities and program, taking into consideration cultural differences in the clients they serve and where the program is, in terms of their own implementation of wellness and recovery principles.

3.2 Mental Health Board Executive Director
Ms. Brooke: The next Police Crisis Intervention Training is April 19-22.

4.0 MENTAL HEALTH BOARD COMMITTEES
Mr. Stinson: Last night, Kate, Chance, and I represented the Mental Health Board at the inaugural meeting of the Behavioral Health Integrated Advisory Committee. This has been a long time coming. My own opinion is that it was a real productive meeting. There was a free flow of ideas. It was an exercise in understanding what 's important from the substance abuse services perspective. We also talked about what was

important from the mental health perspective. We talked about how we can be stronger working together than working alone.

We have committed to meeting on an ongoing basis, initially twice a month, to come up with more formal plans on how to be effective. In a future meeting, we can discuss how our board wants to be represented and what issues we want to put forward.

mr. martin: Ted was referring to the consensus we reached, but one thing we had in common was that the Health Commission roundly ignores our input, and we represent the most stigmatized populations in San Francisco. If we join together we might be able to consolidate our power.

Dr. Del Zotto: I would like to recommend that in April, we do a more detailed presentation and that it become an important part of that meeting.

Mr. Stinson: With regard to the Annual Report, we've had a couple really nice reports for the past few years. This Report is one way we talk with outside world about mental health services. We want to look at who from the MHB wants to work on it. This is going to be published at the end of the fiscal year. I suggest that in the next meeting we spend some time talking about what would be good themes.

Ms. Shaffer: I wrote down 26 things from the presentation tonight that we can follow up on, including in the Program and Services and Children's Committee.

With regard to program reviews, we will be focusing on the programs that haven't been seen for a while. We're updating and streamlining the forms, thanks to Kate who did a great job with this.

Dr. Del Zotto: At the next meeting, it would be good to take time to focus on Kate's handout.

Ms. Walker: I wrote this out to be a talking point in the meeting. Obviously it's not a finished document.

Discussion of future action in response to the presentation
Dr. Turner: I noted three key things: 1) Teaching kids how to deal with their friend's issues. 2) Developing peer counseling programs, models of which are very available. There are a lot of people who willing to provide this. I might be able to help facilitate that connection. 3) Serving as advocates for parents.

mr. martin: The issue of language services merits further discussion. There are lots of mono-lingual non-English speakers in San Francisco.

Ms. Yuen: Working with teens at schools and advocating for parents, ties into the language issue. A lot of people not aware of services due to this and other cultural issues.

Ms. Knight: I was impressed with Galina speaking about what the students need, and having someone from each grade to help guide this.

Ms. Walker: I'd like to see us divide into groups according to interests to multiply our effectiveness.

Mr. Douglas: In a prior incarnation I was a peer counselor with disabled people. There are peer counselors all over. Maybe someone should have a conference to educate and support peer counselors. At our next MHB meeting, maybe we should not have a speaker and have more time to talk about these things.

Dr. Del Zotto: Thank you to Dorothy for arranging our speakers and making this meeting happen tonight.

Ms. Shaffer: We keep hearing training, training. Perhaps the Police Crisis Intervention Training might be a model we could use with the schools. We could collaborate with the school district. Early intervention is critical. So many of the problems could have been prevented if someone had known early, and if someone had helped the parents at the beginning.

5.0 NEW BUSINESS
No new business.

6.0 PUBLIC COMMENTS
Mr. Kalman: Mayor Newsom has instituted a Ten Year Homeless Planning Council. My question is who is representing mental health services on this new council. Can I officially ask you to get mental health representation on the council?

mr. martin: The Executive Director of the Coalition on Homelessness, Paul Boden, and Marykate Connor of Caduceus Outreach Services will both be on the Council.

Mr. Kalman: Can we invite Angela Alioto here for discussion of the homelessness plan?

7.0 ADJOURNMENT
There being no further business, the meeting was adjourned at 8:35 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

Department of Public Health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, April 14, 2004
1380 Howard, Room 537
6:30 p.m.

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AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of March 10, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 14, 2004, to the following members: Bridgett Brown, Toye Moses, PhD.

2.0 DISCUSSION ABOUT MENTAL HEALTH AND SCHOOL DISTRICT COLLABORATION (55 minutes)
For discussion and possible action

Discussion of this Mental Health Board priority and possible follow up to past presentations and committee work.

3.0 DIRECTORS REPORTS (25 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.
Discussion of budget policy and strategy.

4.1.b PROPOSED ACTION: Be it resolved that a letter of support for re-appointment of Roma Guy be approved as submitted.

4.2 Report of the Program and Services and Children's Committee: Discussion of programs to visit, Board goals for these visits, and revised questionnaires.

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

7.0 ADJOURNMENT

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2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

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Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
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Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES
Mental Health Board
Wednesday, April 14, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Augusta Del Zotto, Ph.D. (Acting Chair); Bridgett Brown; Carol Knight, M.A.; Joel Luebkeman; chance martin; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.; Kate Walker; Idell Wilson; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Bob Douglas, J.D.; S supervisor Bevan Dufty; Ted Stinson (Chair).

BOARD MEMBERS ABSENT: Dennis Yun, M.S.W.

OTHERS PRESENT: Edwin Batongbacal (Community Behavioral Health Services); Helynna Brooke (MHB Executive Director).

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:45 p.m. by Augusta Del Zotto, Acting Chair

Dr. Del Zotto requested a moment of silence for the four young men killed in the Bayview within the past couple of weeks, for Officer Isaac Espinoza who was killed, also in the Bayview, this past weekend, and for Rich Snowdon's mother who just passed.

CONSENT CALENDAR

RESOLUTION (MHB-2004-17): Be it resolved that the minutes of the Mental Health Board meeting of March 10, 2004 be approved as submitted. (Passed unanimously.)

RESOLUTION (MHB-2004-18): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 14, 2004, to the following members: Bob Douglas, J.D.; Ted Stinson. (Passed unanimously.)

Dr. Del Zotto announced that Supervisor Michela Alioto-Pier just appointed LaVaughn Kellum-King as out newest Board member. Ms. Kellum-King thanked the Board for their welcome and introduced her son, Noah King.

2.0 DISCUSSION ABOUT MENTAL HEALTH AND SCHOOL DISTRICT COLLABORATION

This agenda item was postponed until after all the rest of the business was taken care of.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services

Mr. Batongbacal reported for Dr. Robert Cabaj:

The Mentally Ill Offender Program which is run by the UC Regents and has been funded by the State, is out of funding, affecting 100 clients. The Southeast Geriatric Clinic merged with OMI Clinic and Team II. They will be centralizing into one location.

There is a wait and see attitude towards the Mayor's Homeless Outreach Plan, but there is a nationwide philosophical movement towards ending homelessness, not just providing services. San Francisco is looking at the Philadelphia model, which is a three-pronged program: 1) aggressive outreach - approach people on the street and ask what do they need, 2) development of resources for permanent housing, 3) wrap-around services to include medical, housing, mental health services and substance abuse services. In the Mayor's Initiative, housing will be prioritized.

mr. martin shared that the street outreach is in the same spirit as the Federal Chronic Homeless Initiative, ignoring the fact that the fastest growing homeless sectors are seniors and women with children. They are targeting the visibly homeless, particularly in areas of town where business might be impacted.

Mr. Batongbacal continued with the information that the Community Behavioral Health Services Dual Diagnosis Team will work with the Mayor's team. They will shift their focus to the streets. CBHS will be very involved and our service delivery system will be responding. Regarding housing, more will be developed. Primary care will also be available. Mobile Crisis will interact with this program too.

Ms. Shaffer pointed out that if Mobile Crisis could get a onetime grant of one million dollars to ramp up to 24/7, they could be in the black before long because they can bill for their services.

Mr. Batongbacal then shared that there is an RFP out for a Behavioral Health Integration Consultant to improve services for the dually diagnosed.

Dr. Moses asked about the Peer Internship Program. Mr. Batongbacal replied that CBHS is creating a community of consumers to provide help to each other. The department is currently seeking applications. Ms. Wilson shared that the stipend is $500 per month for 20 hours per week.

Dr. Moses announced that Supervisor Sophie Maxwell will have a budget hearing in the Bayview in two weeks.

The Director's written report was distributed:

1. Homeless Street Outreach. SF CBHS will assist with Mayor Newsom's plan to send outreach workers onto San Francisco's streets to seek out the most troubled homeless individuals and try to persuade them to move into housing and avail of treatment, including substance abuse, mental health, and medical services.

A homeless street outreach team is being constituted, composed of the 5 staff-members of the CBHS Dual Diagnosis Consultation Team, 2 homeless outreach workers from Department of Human Services, and 3 outreach workers from CATS Mobile Assistance Patrol. This outreach team will eventually have 15 members, and will be headed by David Nakanishi, LCSW, Director of the Dual Diagnosis Consultation Team. The team will begin doing street outreach in May, and will initially focus its efforts in the 'Central City' area (roughly bordered by Van Ness, Geary, Mason and Market Street).

2. Annual Client Council Retreat, April 2004. Seventeen consumer providers, six consumers, and CBHS staff attended the annual Client Council Retreat on Wednesday, April 7, 2004, between 10 a.m. and 3:30 p.m. at Stern Grove Clubhouse. In the morning program, Alice Washington, a consumer provider, facilitated networking and team building skills. Clients shared their vision and perspectives of the Client Council. In the afternoon program, Director of Cultural Competence & Client Relations, Tina Yee, presented an overview of current upcoming changes in the problem resolution/grievance process. Client Council Chairperson, Wing H. Tse, then facilitated a discussion on the use of peer support and peer case management in CBHS. A complete report of this Client Council Retreat will be available in June 2004.

3. Volunteer of the Year. Lee Etta Palmer, who volunteers with the CBHS Pharmacy division, was paid a special tribute in March at the Retired and Senior Volunteer Program (RSVP) recognition luncheon. Lee Etta was chosen from among 1100 older adult volunteers to receive the "2003 Volunteer of the Year" award. This special homage represents RSVP's gratitude for her valuable and generous contribution to the community as an RSVP volunteer.

Lee Etta Palmer has been volunteering with the San Francisco Department of Public Health for 10 years. She was recruited because the CBHS pharmacists were desperate for clerical help, and her presence enabled them to devote more attention to direct clinical care. At one time when staffing was in flux, it was pretty much Lee Etta and the then relatively new pharmacist, Stan, working at the duty desk. Stan says Lee Etta was his left arm, and his right arm ñ and credits her consistent availability as the key factor in keeping the pharmacy running smoothly during a difficult period. Since then, Lee Etta has helped orient most of the Pharmacy division's current staff, including the current Director of Pharmacy, MaryAnn Sullivan. Lee Etta volunteers 5 days a week and has the best attendance in the department.

4. Peer Internship Program. The Peer Internship Program is a paid training opportunity for mental health and substance abuse clients interested in learning how to

be a support to other clients and in developing skills that could lead to gainful employment. The peer support intern performs a variety of duties under supervision, which may include peer case management, socialization, education, skills development, and advocacy. Currently, there are eleven peer interns placed in different behavioral health service placement sites. Eight peer support interns have been hired in full-time or part-time positions at various work sites since August 2003. For Peer Internship Program applications, please contact the Peer Internship Program Coordinator, Wing H. Tse at (415) 255-3672 or the Client and Family Liaison, Wanda Deams at (415) 255-3694.

5. **McMillan Stabilization Pilot Project Open House.** The San Francisco Public Health and Fire Departments along with Community Awareness & Treatment Services (CATS) hosted a 3-day Open House from April 5-7 for the McMillan Stabilization Pilot Project. Invitations were extended citywide to paramedics and emergency room physicians. The purpose of the Open House was to promote better understanding of the McMillan Stabilization Project as well as to encourage utilization.

6. **Vocational Rehabilitation and Employment Support.** The CBHS Vocational Services Committee, with the help of Dr. Saumitra SenGupta and Erin Pirkle, recently completed a review of CBHS client service utilization and cost of service for 1 year pre- and post-enrollment in vocational rehabilitation(VR) and employment support services(ESS). The results indicate significant reduction in cost and utilization of high intensity services including crisis, acute inpatient and long-term care for clients enrolled in VR and ESS. This is accompanied by a corresponding increase in the use of community mental health outpatient services which indicate continued stability for the VR and ESS clients.

Announcement: On April 23, 2004, CBHS will present an all day conference on Psychiatric Collaboration for Employment Success. Dr. Mark Ragins, who is the Medical Director of the Long Beach Village Integrated Service Agency, will be the featured speaker.

7. **Other Upcoming Events.**

RESIDENTIAL CARE CONFERENCE -- A Residential Care Conference is scheduled for Friday, April 23, from 8:30 a.m. - 4:30 p.m. at St. Mary's Conference Center, 1111 Gough St. @ Geary. Barbara Garcia, Bob Cabaj, MD and Marc Trotz will serve as speakers and panelists. The conference will address the complex mental health needs of adult and geriatric residents and their families. The event is co-sponsored by Family Service Agency, Community Behavioral Health Services and a number of other related agencies. For more information, call 474-7310.

2004 CONSUMER AND FAMILY MENTAL HEALTH FAIR -- CBHS salutes May as Mental Health Month with its the 3rd Annual Consumer and Family Mental Health Fair at the San Francisco Main Library, Lower level, on Monday, May 24, 2004, 12 a.m. to 4 p.m.. There will be free refreshment, program with entertainment, videos on various mental health topics, information booths representing consumer and family self-help organizations, mental health and substance abuse programs, from throughout the City. For information, please contact Wanda Deams at (415) 255-3694.

CHINESE COMMUNITY HEALTH SUMMIT -- CBHS is a major co-sponsor of the upcoming Chinese Community Health Summit on Wednesday, May 26, 2004 between 8 a.m. and 4:30 p.m. at the Holiday Inn Golden Gateway at 1500 Van Ness Avenue. The Summit is organized by NICOS Chinese Health Coalition, and is a full day event focused on developing strategies to address health care access and prevention needs of San Francisco's Chinese community. There will be CBHS staff presenting in various panels at the Summit. For pre-registration, please contact Jeanne Kwong at (415) 255-3427.

LESBIAN MENTAL HEALTH CONFERENCE -- Community Behavioral Health Services (CBHS) is sponsoring a conference entitled, "SF LGBT Pride Celebration : Current Challenges in Lesbian Mental Health," on Friday, June 25. This conference will be of particular interest to Primary Care providers as well as other DPH staff working in the field of mental health. For the registration material and complete description please go to:
http://www.dph.sf.ca.us/MentlHlth/lesbianMentalMlthbroch406252004.pdf .

3.2 Mental Health Board Executive Director
Ms. Brooke: The next Police Crisis Intervention Training is April 19-22. Mental Health Board members Augusta Del Zotto and Bob Douglas will be participating this time. All Board members are welcome to attend the graduation on April 22nd. Ms. Brooke reminded Board members about the city's presentation about Sunshine laws on May 3rd at Herbst Theater in the War Memorial Building on Van Ness. She passed out a flyer describing the meeting.

4.0 MENTAL HEALTH BOARD COMMITTEES

RESOLUTION (MHB-2004-19): Be it resolved that a letter of support for re-appointment of Roma Guy be approved as submitted. (passed unanimously.)

Dr. Del Zotto said that Board members should consult the handout they have highlighting programs that have not been reviewed by the Board in a number of years and list a couple of programs on the sheet that Ms. Brooke is passing out that they would like to review. The Board needs to do a minimum of four more reviews by the end of the fiscal year in June.

2.0 DISCUSSION ABOUT MENTAL HEALTH AND SCHOOL DISTRICT COLLABORATION
(Taken out of order.)

Ms. Shaffer facilitated a discussion about action items the Board could do to encourage greater collaboration between Community Behavior Health Services and the San Francisco Unified School District. She began the discussion by sharing that although three people presented at the last board meeting, we had ten parents who decline our invitation because they feared retribution from the school district if they spoke about their issues.

Reviewing the concerns raised, three issues stand out - training and education, prevention and early intervention, and stigma. Ms. Shaffer highlighted the high suicide ideation by students in the schools.

Mr. Luebkeman asked if we wanted to focus on suicide prevention or depression in schools.

Ms. Shaffer mentioned that Galina Youdovic, the Lowell High School student who spoke at the last MHB meeting, suggested a Wellness Board that would have student representatives from all of the high schools. She encouraged the MHB to support the student's efforts to create this Wellness Board. Ms. Shaffer stressed the importance of asking youth what they need.

It was suggested that it would be good to have a psychologist liaison from mental health to the school district.

Dr. Del Zotto stressed the importance of asking parents for their feedback.

Ms. Shaffer asked if it would be possible to obtain a definitive list of what services are already being provided to the schools by children's mental health services. She said that 11% of students reported carrying a club, gun, or knife during the 30 days that preceded a recent survey.

Dr. Turner talked about multiple contributions to stress impacting youth.

Ms. Shaffer mentioned the mayor's presentation regarding building bridges between schools and the city.

Ms. Turner suggested that we look at services that are physically located near particular schools. She asked about the availability of anger management training for youth.

Dr. Del Zotto said that it can be found at some schools but not all.

Ms. Shaffer said that the goal is to come up with a Mental Health Board action that is doable by the Board.

Dr. Del Zotto listed on the blackboard the key issues rasied during the discussion:

* Violence in the schools
* What Sai-Ling Chan-Sew's team needs for support
* Connecting neighborhood support services to schools
* Information on support services for parents
* What the Youth Commission needs for support
* Seek feedback about the Day of Kindness from youth

Ms. Shaffer stated that many parents don't know they have the right to have a psychological assessment for their child. Many teachers don't know this either.

Dr. Del Zotto suggested that it might be helpful if parents were given a brochure with this information. It might also include information about services near each school. This would work well with Dr. Ackerman's vision for neighborhood schools.

Ms. Yuen mentioned that there are lots of other organizations outside of city programs that work with schools, such as Suicide Prevention. The staff went out to schools and presented to students about risky behaviors, gangs, suicide, etc. They worked with science and health teachers collaborating with these programs. She suggested that we develop resolutions to support programs that are providing services to schools.

Ms. Walker suggested that we send the list of things that kids want around.

mr. martin asked about the role that the Youth Commission might play on this issue. He suggested that we invite the Youth Commission to speak to the Board.

Ms. Yuen said that we need buy in from the top down.

Ms. Turner suggested that we connect with the school board.

Dr. Del Zotto suggested inviting Mark Sanchez to one of our Board meetings.

5.0 NEW BUSINESS

Mr. Luebkeman suggested that we provide some time on the agenda for Board members to present about the programs they have reviewed.

6.0 PUBLIC COMMENTS

A member of the public shared concern about children being bullied in schools, resulting in mental health issues for students.

7.0 ADJOURNMENT

There being no further business, the meeting was adjourned at 8:30 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, May 12, 2004
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of April 14, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 12, 2004, to the following members: Dr. Toye Moses

2.0 PUBLIC HEARING CO-SPONSORED WITH SUPERVISOR BEVAN DUFTY ON BEHAVIORAL HEALTH ISSUES WITH CRYSTAL METHAMPHETAMINE ADDICTION (45 minutes)

Speakers to be announced.

2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

3.0 DIRECTORS REPORTS (25 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.
Discussion of budget policy and strategy.

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

7.0 ADJOURNMENT

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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Sunshine Ordinance Task Force
City Hall, Room 244
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Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, May 12, 2004
1380 Howard, Room 537
6:30 p.m.

revised

UPDATED AGENDA

BUDGET ITEM 4.1.a ADDED

Public comments will be taken for each agenda item.

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For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.
Discussion of budget policy and strategy.

4.1.a RESOLUTION: Regarding the historic budget crisis in San Francisco and recommended strategies for responding to it. (Attachment A)

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Suggestions for future agenda items or issues the Board might consider looking into.

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MENTAL HEALTH BOARD
ATTACHMENT A
May 12, 2004

PROPOSED RESOLUTION (MHB-2004-xx): RESPONDING TO THE BUDGET CRISIS

WHEREAS, the City and County of San Francisco is facing it's largest deficit in history; and

WHEREAS, public health services are facing devastating cuts; and

WHEREAS, with regard to mental health services, the Bronzan-McCorquodale Act of 1991 (Section 5600 and following in the State Welfare and Institutions Code) outlines a complete system of care as the most effective and cost-efficient way to provide services and mandates that Counties to the best of their ability provide a comprehensive system of services, and

WHEREAS, in San Francisco, Community Behavioral Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, which meets the Bronzan-McCorquodale guidelines, and whereas, cuts will fragment that system and damage its cost effectiveness strategies, and

WHEREAS, a severe cut will mean that many clients of the mental health system who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, inpatient units at San Francisco General Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save, and

WHEREAS, the Mental Health Board further believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to respond to this crisis with a comprehensive revenue strategy, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the art services the city has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the sustainability of the community-based nonprofit organizations which deliver such a large percentage of its public health services, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured working citizens, and

BE IT FURTHER RESOLVED, in summary, that San Francisco be a role model and deliver a message to our nation about the importance of protecting our infrastructure and protecting all of our citizens, even, or especially, during a time of international crisis and danger, and that we not end up losing the very things we are seeking to defend.

FY04-05 CBHS Contingency

PROPOSAL:

1. Integrate four Mental Health (MH) and Primary Care (PC) clinics and transition other clients to CBOs.
2. Transition Mission ACT clients to lower level of care.

GOALS AND OBJECTIVES:

- Streamline services for mentally ill clients by integrating behavioral and physical health
- Transition clients to providers based on client stability
- Maintain current client capacity
- Achieve administrative and clinical efficiency
- Maximize space utilization in civil service and community based capacity
- Cost savings as a result of the above

METHODOLOGY

1. Identified MH and PC clinics that could be collocated. This was based on several factors, including the overlap of clients in both systems, the feasibility of a PC clinic to accommodate new clients, client compatibility, and ownership of property. Clients not integrated into PC will be transitioned to CBOs because they can maintain the same civil service treatment level. Stable clients (discussed below) will go to the PPN, but this should happen anyway and isn't really part of the initiative

2. Mission ACT client transition will take place to allow clients who are ready to transition to move to a lower level of care, and retain clients at the SPR level who aren't ready.

3. Determined the cost of serving clients in the clinic, in the PPN and in CBO. The annual cost per client in a civil service clinic was calculated by dividing the total cost of the clinic by the number of unique clients active in the past six months. The same average cost was applied to the number of clients moving to CBO's. The thought is that CBO's won't also need to increase indirect costs.

4. After we determined the client allocation, then we calculated the actual cost of the proposed staffing mix to be moved to the PC clinic. We revised the numbers to ensure that these civil service staff were funded in the appropriate level, which in some cases lowered the clients moving to the community.

5. To determine the number of clients who could transfer to the PPN, an analysis was conducted of clients with meds only. This was used as an indicator of stability and consideration for transfer. Clients from Sunset and Mission will be transferred to PPN. In the other clinics it was not possible to maintain the required level of civil service staffing and fund the PPN, and since the PPN amount was minimal, there was no impact.

Revenues:
SD/M-Cal will be claimed for clients in the PC clinics, and not FQHC. PC staff will transfer into CBHS budget so that they can bill SD/M-Cal. Some revenue loss will occur due to lower rates in community programs.

6. Next Steps:
    a. Notification
    b. Implementation Brainstorming
    c. RFP process
    d. Client transition

CURRENT BUDGET

	FTE	Personnel	Operating	Total
Sunset Mental Health	20.20	2,103,955	46,460	2,150,415
Mission Team II	5.05	510,535	13,800	524,335
Mission ACT	14.29	1,220,033	241,826	1,461,859
Central City Seniors	7.80	888,826	17,940	906,766
Mission ISC	21.12	2,150,692	48,576	2,199,268

REALLOCATION

Sunset	Clients		Total Budget	Overlap Clients Served in Primary Care
Community-Based Alternatives	350		603,400	
PPN-Network	150		129,300	
Backfill Baseline PPN			63,000	
Ocean Park Primary Care	600		1,219,175	255
Total	1100		2,014,875	

Mission Team II	Clients		Total Budget	Overlap Clients Served in Primary Care
Castro Mission	217		524,335	35
Total	217		524,335	

Mission OP	Clients		Total Budget	Overlap Clients Served in Primary Care
Non-Profit(s)	600		990,000	
Private Provider Network	100		86,200	
Tom Waddel	200		863,533	183
Total	900		1,939,733	

Mission SPR				
	Clients		Total Budget	
Non-Profit(s)- Existing SPR	50		730,000	
Non-Profit-Intensive Case Mgmt.	50		500,000	
Total	100		1,230,000	

Older Adult (aka Central City Seniors)				
	Clients		Total Budget	
Curry Senior Center-Prim. Care	265		905,885	
Total	265		905,885	

FTE REDUCTIONS

FTE Reductions	FY03-04 FTE	FY04-05 FTE Proposed	Variance
Sunset	20.20	10.64	-9.56
Older Adult	7.80	7.80	0.00
Mission ISC	21.12	8.38	-12.74
Mission Team II	5.05	5.05	0.00
Subtotal	54.17	31.87	-22.30
Mission ACT	14.29		-14.29
Total 12 Mos.	68.46	31.87	-36.59
Total 10 Mos.	57.05	26.56	-30.49
# Employees Impacted			46

Initiative Number _____
(Leave blank)

DEPARTMENT OF PUBLIC HEALTH
2004-2005 Program Reduction

- ☐ San Francisco General Hospital
- ☐ Laguna Honda Hospital
- ☐ Primary Care
- ☐ Jail Health
- ☐ Health At Home
- ☐ Administration
- ☐ Public Health
- ☒ CBHS- Mental Health
- ☐ CBHS- Substance Abuse

DPH PROGRAM: Community Behavioral Health Services (CBHS) – Mental Health
PROVIDER NAME, CONTACT & ADDRESS:
PROGRAM / INITIATIVE TITLE: Integration of Four Adult Mental Health Clinics with Primary Care Clinics

AMOUNT: $5,343,121	Total Budget- 10 Months
<$4,487,787>	Reallocation of Services
<$83,333>	Revenue Reduction
$772,000	General Fund Savings
$3,000,000	Estimated value of building sale
$3,772,000	Revised General Fund Savings – 10 Months

TARGETED CLIENTS: Adult Mentally Ill Clients

PROGRAM DESCRIPTION: (Description of Program Change)
(If proposing reductions to Contractors, provide name of contractor, program and amount)

The purpose of the proposed initiative is to streamline and enhance client care by integrating mental health and primary care services, while at the same time achieving staffing and operating efficiencies that will result in General Fund savings. Specifically, four adult mental health clinics will be integrated with four primary care clinics. These clinics are as follows: Sunset Mental Health Clinic will be co-located with Ocean Park Primary Care Clinic; Mission Team II Mental Health Clinic with Castro Mission Primary Care; Mission Mental Health with Tom Waddel Primary Care; and Older Adult Mental Health Clinic with Curry Senior Center Primary Care Clinic. Additionally, some clients will be re-located to community-based alternatives. This will enable the Department to maximize the capacity in the community-based service system, a key component of the City's mental health delivery system, without decreasing the level of care needed by the clients. It will also enable the Department to generate $3.0m through the sale of the Sunset Mental Health Clinic facility and enable the Department to save $772k on an ongoing basis due to no longer paying rent and associated costs for Mission Team II, Mission Mental Health and Older Adult Mental Health Clinics.

Mental Health staff and clients will be relocated to the primary care clinic sites as noted above, and not vice-versa due to the facility requirements for primary care services, such as sinks in the exam rooms. The particular pairings were selected based on the proximity of the clinics to each other, the overlap of clients between the clinics, the population focus, and the capacity to absorb additional staff and clients at the primary care sites. Planning is currently underway for any necessary clinic renovations, such as the installation of elevators which will enable the clinics to expand capacity. These renovations will take place regardless of the outcome of the subject proposal because the renovations will improve disability access and maximize the available space.

JUSTIFICATION: (required by the Mayor's Office)

In FY02-03, the Department conducted an analysis to determine the overlap of clients seen in both the primary care and the mental health systems. It was determined that 10,000 clients were seen simultaneously in both the mental health and primary care systems of care. The proposed initiative will result in a more convenient and efficient service delivery for clients with both physical and behavioral health needs. The integration is expected to provide clients with a more comprehensive set of treatment options to address their multiple needs in one location, and by making the delivery of services more convenient to the clients, it is expected that clients will be more likely to remain in treatment for the duration of the treatment period needed to address their symptoms.

IMPACT ON NUMBER OF CLIENTS SERVED AND UNITS OF SERVICE PROVIDED

The proposal will accommodate all active clients seen in the four mental health clinics. In all, the Department expects to transfer 2,482 clients to new sites. Although the Department acknowledges that the transition period will be challenging to all involved, the goal is to ensure that clients are transitioned with minimal inconvenience and loss of service. The clients will be transitioned as follows:

Client Relocation	Sunset	Mission Team II	Mission ISC	Older Adult
Clients to Primary Care	500	217	200	265
Clients to Community Based Alternative	600	N/A	700	N/A
Total	1,100	217	900	265

EXPENSE AND REVENUE IMPACT (Reductions/Reallocations-complete supporting budget doc)

Expenditures are expected to decrease by $855,333, and Revenues are expected to decrease by $83,333, for total General Fund savings of $772k. Additionally, the Department expects to gain $3.0m through the sale of a City-owned facility that will be vacant after the co-location of the clinics is complete.

IMPACT ON DEPARTMENT'S WORKFORCE (increase or decrease of FTE's)

The net reduction in FTE will be 18.58 FTE effective September 1, 2004, and 22.30 FTE on an ongoing basis.

ATTACHMENT B
SUMMARY OF PROGRAM COST

INITIATIVE TITLE: Integration of Four Adult Mental Health Clinics and Primary Care Clinics

		FY 2004-05 (10 Months)	Ongoing
Sources:			
45416	Short Doyle Medi-Cal Revenue	(83,333)	(100,000)
Subtotal Sources		(83,333)	(100,000)
Uses:			
	Operating	$ (46,075)	$ (55,290)
	Rent	$ (522,771)	$ (627,325)
	Sale Of Land	$ (3,000,000)	$ -
001	Salaries	(1,564,749)	$ (1,877,699)
013	Man. Fringe Benefits	(281,655)	$ (337,986)
027	Reallocation to Professional Services	$ 1,559,917	$ 1,871,900
Subtotal Uses		(3,855,333)	(1,026,400)
Net General Fund Subsidy Required (Uses less Sources)		$ (3,772,000)	$ (926,400)
Total FTE's			

New Positions (List positions by Class, Title and FTE)

Class	Title	FTE's	
1444	SECRETARY I	(1.67)	(75,690)
2230	PHYSICIAN SPECIALIST	(2.88)	(379,840)
2232	SENIOR PHYSICIAN SPECIALIST	(0.94)	(137,167)
2305	PSYCH. TECHNICIAN	(0.83)	(48,872)
2306	SENIOR PSYCH ORDERLY	(0.83)	(50,830)
2320	REGISTERED NURSE	-	-
2328	NURSE PRACTITIONER	(0.83)	(86,108)
2566	REHAB COUNSELOR	(0.83)	(49,612)
2574	CLINICAL PSYCHOLOGIST	(2.48)	(206,954)
2930 *	PSYCH SOCIAL WORKER	(3.95)	(284,336)
2931	MFCC	(1.67)	(119,973)
2932	SENIOR PSYCH. SOCIAL WORKER	(1.67)	(125,367)
Total Salaries		-	(1,564,749)
Fringe (18%)			(281,655)
Total Personnel		(18.58)	(1,846,404)

Operating Expenses (List by Character)

03000	Rent/Janitorial	(522,771)
049	Office Supplies and Furnishings	(22,566)
031	Photocopy costs	(2,137)
035	Postage/Mailing	(2,220)
081ET	Telephone/Data	(5,180)
081TE	Pagers/Cell Phones	(360)
081UL/081UW	Utilities	(11,520)
081PA/081PF	Vehicle Maintenance & Fuel	(2,091)

Re-allocation	to 027 Professional Services	1,559,917

* .83 FTE 2930 is in index code HMHMCP751594
All other expenses are in the community care HMHMCC730515 index code

Initiative Number _____
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DEPARTMENT OF PUBLIC HEALTH
2004-2005 Program Reduction

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- ☐ Primary Care
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- ☐ Administration
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- ☒ CBHS- Mental Health
- ☐ CBHS- Substance Abuse

DPH PROGRAM: Community Behavioral Health Services (CBHS) – Mental Health
PROVIDER NAME, CONTACT & ADDRESS: Bob Cabaj, M.D., Director of CBHS, 255-3401
PROGRAM / INITIATIVE TITLE: Step-Down Transition for Clients in the Mission Assertive Community Treatment (ACT) Program

AMOUNT: $1,577,057	Total Budget- 10 Months
<$1,025,000>	Reallocation of Services
<$91,667>	Revenue Reduction
$460,390	General Fund Savings-10 Months

TARGETED CLIENTS: Adult Mentally Ill Clients in Mission ACT

PROGRAM DESCRIPTION: (Description of Program Change)
(If proposing reductions to Contractors, provide name of contractor, program and amount)

The proposed initiative will close the civil service Mission Assertive Community Treatment (ACT) facility, and reassign the 100 clients to (a) an intensive case management program- 50 clients, or (b) one of two existing non-profit ACT programs, depending on their level of need. The goal of the initiative will be to transition all clients who are ready to step-down to a lower level of care to this level of care, and continue the same level of services for those clients who aren't yet ready to transition. The Department will conduct an RFP for the provision of intensive step-down services for clients following their ACT treatment episode.

An ACT treatment model is used to meet the needs of clients who have severe psychiatric disorders and are high users of the mental health system by providing intensive comprehensive services, such as case management, with an overall goal of stabilizing the clients and reducing costs. Treatment providers are paid a per client per month capitated rate, as opposed to the traditional fee-for-service system utilized for most treatment programs.

The Department has operated three SPR programs since FY97-98, serving a total of 400 clients at any given time. These programs were selected based on an RFP process. There are two community-based programs and one civil service operated program. A study conducted of the ACT programs in FY02-03 shows that of the 100 patients at the Mission ACT program, 79 percent of the clients have been in the program for over five years (as compared to 65 percent and 58 percent of the clients in the other two programs), and 34 percent of the clients have had no inpatient/PES visit for over five years (as compared to 25 percent and 24 percent for the other two programs), and for an additional 18 percent of the Mission ACT clients, their last PES or inpatient visit was from three to five years ago. Based on this data, the Department has concluded there is a high level of stability among the clients in the Mission ACT program, and therefore many of these clients are ready to transition to a lower level of care.

JUSTIFICATION: (required by the Mayor's Office)

The ACT programs are one of the most expensive and intensive service programs offered. As a result of the service intensity, these programs are very successful in lowering hospital usage and increasing housing stability. As the three programs are six years old, however, the point has been reached where many of the clients are ready to be transitioned to a lower level of service. A research paper summarizing 75 studies, mostly related to ACT programs and intensive case management programs, indicates that those patients who use services in relatively low levels and/or who have made significant gains in functioning can be transferred to less intensive levels of services without bad effects. Further, a study of clients who had been in intensive case management for two years following five years in an ACT model were not found to have significant changes in hospitalization rates. As the Department believes that many of the Mission ACT clients have reached the transition point and no longer need the most intensive level of care, the Department is proposing the implementation of a step-down level of care that is expected to be as effective for these more stabilized clients at a lower cost. Clients from the other two ACT programs will also be able to benefit from this resource as slots open up. For those clients who are not stable enough, or for clients who are later determined not to be stable enough for the lower level of care, the Department will also increase the number of slots available in the other two ACT programs, so all clients will be provided with the appropriate level of intensive services.

IMPACT ON NUMBER OF CLIENTS SERVED AND UNITS OF SERVICE PROVIDED

The Mission ACT program serves 100 clients. Of these clients, 42% are Hispanic, 39% are White, 9% are African American, 1% is Chinese, and 3% is unknown. Due to the high percentage of Hispanic clients, the Department will ensure that the providers receiving these clients possess the appropriate language and cultural competence levels to adequately address the clients' needs.

EXPENSE AND REVENUE IMPACT (Reductions/Reallocations-complete supporting budget doc)

Net Expenditures (after the reallocation of $1,025m to 027 Professional Services) are expected to decrease by $460,390, and Revenues are expected to decrease by $91,667. The expenditure reduction includes a rent savings of $358,842 for 10 months. The Mission ACT program, located at 2712 Mission Street shares space with the Mission OP program, which is also proposed to close in FY04-05.

IMPACT ON DEPARTMENT'S WORKFORCE (increase or decrease of FTE's)

The net reduction in FTE will be 11.91 FTE effective September 1, 2004 and 14.91 FTE ongoing.

ATTACHMENT B
SUMMARY OF PROGRAM COST

INITIATIVE TITLE: Mission ACT Step-Down Transition

		FY 2004-05 (10 Months)	Ongoing
Sources:			
45416	Short Doyle Medi-Cal Revenue	(91,667)	(110,000)
Subtotal Sources		(91,667)	(110,000)
Uses:			
	Operating	$ (201,522)	$ (241,826)
	Rent	$ (358,842)	$ (430,610)
001	Salaries	(861,605)	$ (1,033,926)
013	Man. Fringe Benefits	(155,089)	$ (186,107)
027	Reallocation to Professional Services	$ 1,025,000	$ 1,230,000
Subtotal Uses		(552,057)	(662,469)
Net General Fund Subsidy Required (Uses less Sources)		$ (460,390)	$ (552,469)
Total FTE's			

New Positions (List positions by Class, Title and FTE)

Class	Title	FTE's	
1426	SENIOR CLERK TYPIST	0.83	(39,737)
1444	SECRETARY 1	0.83	(37,845)
1822	ADMIN. ANALYST	0.83	(56,311)
2232	SENIOR PHYSICIAN SPECIALIST	0.83	(121,387)
2305	PSYC. TECHNICIAN	0.83	(48,872)
2320	REGISTERED NURSE	0.83	(66,816)
2550	SENIOR OCCUP. THERAPIST	0.67	(61,544)
2552	DIR OF ACTIVITIES	0.83	(56,855)
2566	REHAB COUNSELOR	0.83	(49,612)
2588	HW IV	0.83	(50,591)
2930	PSYCH SOCIAL WORKER	0.83	(59,987)
2930	PSYCH SOCIAL WORKER	0.41	(29,393)
2930	PSYCH SOCIAL WORKER	0.83	(59,987)
2931	MFCC	0.83	(59,987)
2932	SENIOR PSW	0.83	(62,684)
Total Salaries			(861,605)
Fringe (18%)			(155,089)
Total Personnel		11.91	(1,016,694)

Operating Expenses (List by Character)

03000	Rent/Janitorial	(358,842)
049	Office Supplies and Furnishings	(12,325)
031	Photocopy costs	(2,500)
035	Postage/Mailing/Water	(844)
081TE	Pagers/Cell Phones	(708)
081UL/081UW	Utilities	(5,600)
081PA/081PF	Vehicle Maintenance & Fuel	(5,412)
027	Westside	(174,133)
Re-allocation	to 027 Professional Services	1,025,000

Initiative Number _____
(Leave blank)

2004-2005 Program Change Request

DEPARTMENT NAME:

- ☐ San Francisco General Hospital
- ☐ Laguna Honda Hospital
- ☒ Primary Care
- ☐ Jail Health
- ☐ Health At Home
- ☐ Public Health
- ☐ CBHS- Mental Health
- ☐ CBHS- Substance Abuse
- ☐

DPH SECTION: Primary Care Health Centers
PROGRAM CONTACT NAME/PHONE: Barbara Garcia, Deputy Director of Health, 255-3525
PROGRAM / INITIATIVE TITLE: PRIMARY CARE RESTRUCTURE
AMOUNT: ($2,471,276) 10-Month Savings in FY04/05, ($2,965,532) Savings Ongoing

TARGETED CLIENTS: Patients at the eight Community Oriented Primary Care Health Centers, including Castro-Mission, Maxine Hall, Southeast, Chinatown, Ocean Park, Potrero Hill, Silver Avenue, and Tom Waddell Health. The only health center not included is the Curry Senior Center (because it is a combined civil service and community-based organization).

PROGRAM DESCRIPTION: (Description of Program Change)
(If proposing reductions to Contractors, provide name of contractor, program and amount)

The purpose of this initiative is to bring staffing levels and client capacity into balance at each of eight primary care health centers to both maximize efficiency and achieve savings, as well as ensure equity in resources across the clinics. To achieve this goal, the Department determined the maximum number of medical providers (physicians, residents and nurse practitioners) required for each clinic based on the number of exam rooms. A per-provider national industry benchmark (with a public health factor added) was used to determine and standardize the level of support per provider required to achieve maximum efficiency. The support staff include nursing, clinical support and clerical support staff.

The proposed initiative did not change the level of staffing for dental, podiatry, or behavioral health services. The proposed initiative does result in the elimination of evening hours for General Fund funded programs, which will impact one clinic, Castro-Mission. Additionally, the proposed initiative will reduce the level of services provided by satellite clinics. There will be a 50% reduction in General Fund funded staff for the satellite clinics, (an overall 27% reduction of all satellite staff, including a 3.6 percent reduction in direct service providers).

JUSTIFICATION: (required by the Mayor's Office)

Primary Care staffing is not currently optimized because the number of support staff is not balanced with the providers they support. If staffing is correctly rebalanced, the clinics will be equitably staffed, and overall costs will be reduced.

IMPACT ON NUMBER OF CLIENTS SERVED AND UNITS OF SERVICE PROVIDED

Overall, there will be a 13.8 percent reduction in direct service provider FTEs. The reduction is composed of a 3.6 percent reduction as a result of reduced satellite clinic hours and 1.4 percent reduction as a result of closing Castro-Mission evening care hours – both of which will result in service reductions (The percentage decrease in services is assumed to be equal to the percentage reduction in provider staffing, i.e. 3.6 percent fewer clients will be seen in the satellite clinics). The remaining 8.8 percent reduction is the result of realigning providers to each clinic's capacity during daytime clinic hours. Under this proposal, the Department believes that room utilization will be maximized and more patients will be seen in a more efficient manner, so the percentage reduction in provider staff FTE does not represent a reduction in clients served.

EXPENSE AND REVENUE IMPACT (Reductions/Reallocations-complete supporting budget doc)

Labor expense will decrease by $2,754,612 and non-labor expense will decrease by $313,656 in FY04/05. Patient revenue in the eight affected health centers will decrease by 13.8% or $596,992, which is equal to the percentage decrease in providers (See Box Above); however after the implementation phase, this reduction should be less due to an expected increase in efficiency related to the new staffing model. The resulting 10-month General Fund savings will be $2,471,276 in FY04-05, and $2,965,532 in annual savings thereafter.

IMPACT ON DEPARTMENT'S WORKFORCE (increase or decrease of FTE's)

Primary Care positions will decrease by 26.60 FTE in FY04/05, effective 10/1/04. Details are attached.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

UNADOPTED MINUTES
Mental Health Board
Wednesday, May 12, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Bob Douglas, J.D.; Supervisor Bevan Dufty; Carol Knight, M.A.; Joel Luebkeman; chance martin; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.

BOARD MEMBERS ON LEAVE: Toye Moses, Ph.D., M.P.H.; Kate Walker; Sandy Yuen; Dennis Yun, M.S.W.

BOARD MEMBERS ABSENT: Idell Wilson.

PRESENTERS:
David Ibarguen
Michael Siever, Executive Director, Stonewall Project
Colette I. Hughes, Clients Rights Advocacy Services
Beverly Graham, Westside Crisis Clinic

OTHERS PRESENT: Dustin Blake (Staff to Supervisor Dufty); Robert Cabaj (Community Behavioral Health Services); Edwin Batongbacal (CBHS); Mickey Shipley (Client Advocate, Mental Health Association-San Francisco, Conard House, San Francisco Network of Mental Health Clients); Geoffrey Grier, (Chair, Treatment on Demand Planning Council; Recovery Theatre); Barbara Farrell (Treatment on Demand Planning Council, Ohlhoff Recovery Program); Phyllis Spanglet (former Mental Health Board Member); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:48 p.m. by Ted Stinson, Chair.

Mr. Stinson: I would like to welcome all the members of the public this evening and look forward to your comments tonight.

CONSENT CALENDAR

Postponed until later in the meeting.

2.0 PUBLIC HEARING CO-SPONSORED WITH SUPERVISOR BEVAN DUFTY ON BEHAVIORAL HEALTH ISSUES WITH CRYSTAL METHAMPHETAMINE ADDICTION

Postponed until after the Director's Report.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services

Dr. Cabaj: Our report tonight is quite lengthy.

You've probably seen in the press, the beginning of the Mayor's new Homeless Outreach Team and Edwin Batongbacal, who's here tonight, been very involved in that. Reports have also been on the radio. The Team works from 5 a.m. in the morning to 1 a.m. at night. The article in the paper pointed out that the team has been respectful and if someone has not wanted treatment, the team says okay.

We have done the integration of behavioral health services. We now have hired consultants to help us with the system needs and clinical issues. I've worked with some of these consultants in the past. I was in training with Dr. Minkoff, and this is our fourth decade of doing different projects together.

With regard to the budget, last night there was a hearing held by the Health Commission on the contingency budget. It's not good news.

The Mayor wanted $34 million in cuts. We gave him $19 and he seemed to be okay with that, for which I was very glad. But the contingency budget includes closing four of our mental health centers. We would combine some programs with primary care.

At the end of the Health Commission meeting they decided that they would go with the contingency cuts. But the Commissioners are concerned especially about closing Mission Mental Health and asked us to look at other options there.

Ideally none of these cuts would be needed. But the indications are that we will need to make at least some of these contingency cuts.

I'm losing 12 administrative staff in this building. About half the staff in Mission Mental Health, Mission Act, and Sunset would be eliminated. The older adult program on Van Ness would move in with the Curry Senior Center. Team II would be preserved except for the director's position.

This will be a huge problem for the staff involved. It would mean a lot of physical changes at the clinics. Many clinics don't have elevator access to the second floor, so the logistics would be very challenging. The plus side is that this helps move us forward in terms of integration, though I'd rather have done this in a more natural way and at a slower pace.

Under civil service rules, staff with seniority can bump those with less seniority. So even clinics that are not being cut can be shaken up by staff changes.

Mr. Luebkeman: The clinics slated for closure, what's the average number of years they have been open? Dr. Cabaj: The clinics have all be open for many decades, though not necessarily in their current location. Mission has been in their current building only a couple years. Sunset has been in the same location since the 1940s.

Mr. Luebkeman: So these programs have been part of the community for many decades. Dr. Cabaj: Yes. For many of our clients, knowing you can just walk down the street to get mental health services is crucial.

Ms. Shaffer: Where will the Sunset people go? Dr. Cabaj: They'll go to the Ocean Park Clinic on Kirkham.

Dr. Cabaj: The Mayor has a special interest in Substance Abuse Services.
Mental Health is getting cut $10 million of $19 million in Genreal Fund cuts for all of DPH in terms of contingency cuts. CBHS Children's Services have not been cut. The State has restored its cuts to the Children's System of Care. We will keep our transitional youth focus.

Ms. Shaffer: I think it would be good to look at more opportunities for collaboration.

Dr. Cabaj: The Mental Health Services Act qualified to be on the state ballot in November. It could create up to $700 million or more in new money for mental health services.

We're trying to keep our services level for indigent clients. Other counties are dealing with the crisis by cutting services to indigent clients and by cutting substance abuse services if they had them in the first place.

There is also a proposal to create a local Vehicle License Fee in San Francisco. Supervisor Bevan Dufty and Assembly Member Mark Leno are advocating for it strongly, but the Governor so far is not letting us do it and I don't know what his rationale is.

Mr. Shipley: Are the primary care staff trained in working with mental health clients? If you transfer our clients to a new place with new staff, there's not going to be that trust relationship there. It's going to be very hard on many people. I know this because it happened to me a lot. If that happens, we're going to have people possibly going back into the hospital and we know how much that costs. Even if they have a wrap around team working with them, it's going to be emotionally challenging.

Dr. Cabaj: These are important issues. Half the mental health staff would move with the clients. With primary care staff, at least half their work is already behavioral health. We're looking at all the logistics, in case we have to do this.

Supervisor Dufty: I've gotten some e-mails in the last week that some patients are being released to Laguna Honda who the staff are not prepared to handle, patients with severe psychiatric conditions.

Dr. Cabaj: This is a complicated question. It's part of a new patient flow plan. Mitch Katz has decided to include the rest of DPH in the patient flow plan. There are excellent psychiatrists and staff at Laguna Honda, but some of the staff are angry because they are used to having a quieter set of clients. The clients have not been complaining, but the staff have.

Ms. Brown: You were talking about downsizing the centers and clinics. What will happen to consumer positions? Dr. Cabaj: Right now they are not being cut. I'm trying to grow consumer roles in our system.

Mr. Grier: With all these changes, are you going to shore up primary care and mental health so they would have specific alliances with substance abuse? Mental health is at capacity already. There needs to be a stringent alliance between mental health services and substance abuse services.

Dr. Cabaj: There are no further cuts in substance abuse services right now. We're looking at co-locating Mission Mental Health with some of the Substance Abuse Services. Our consultants are going to help us with this issue, too.

The Director's written report was distributed:

1. 04-05 DPH Contingency Budget. This week, $19.7 million dollars in additional contingency cuts have been proposed for the Department of Public Health's budget for FY 04-05, bringing the total proposed DPH General Fund reductions for FY 04-05 to $32.3 million.

The new proposed contingency cuts include plans to close four Civil Service mental health clinics —Central City Older Adults Mental Health Clinic, Mission Mental Health, Sunset Mental Health, and Team II MH Clinic—and re-locate some of their staff to nearby public primary care clinics. Mission Assertive Community Treatment program is also proposed to be cut. Some of the cut services will be contracted out to non-profit community based organizations. The closure of these mental health program sites will result in a total of $4.2 million in net GF savings for FY 04-05, largely from the sale of the Sunset Mental Health facility ($3M), and rent savings.

As much as possible, the level of direct services to clients will be preserved. A major challenge for CBHS would be to ensure that clients are not lost in the transition of re-locating their services to other sites, and to other providers. A number of overlap clients are actually already receiving services from the primary care clinics to which their mental health services will be relocated, and will benefit from the receipt of both services in one site. The co-location of mental health and primary care services into integrated sites will also ultimately benefit the clients receiving services there.

Administration and operation cuts are also proposed all across DPH, primarily in high-level administrators and middle management positions in program administration, information systems, finance, human resources and clerical support.

2. San Francisco Homeless Outreach Team. The Mayor's new San Francisco Homeless Outreach Team (SF HOT) started doing outreach to homeless individuals in the streets of the Tenderloin on Tuesday, May 10. The Team's mission:

"To provide and advocate for human services to the disenfranchised and those struggling with homelessness by increasing hope, opportunity and recovery of life in order to achieve a higher level of well being."

The team will use a "linkage case management" model, where the focus is on linking or re-linking the clients with other systems of care, so that the team members can be free to continue to outreach to new homeless individuals on an ongoing basis.

Headed by David Nakanishi, LCSW, SF Homeless Outreach Team is currently composed of 5 Outreach Counselor Drivers from the Mobile Assistance Patrol, augmented by CBHS (DPH) and Department of Human Services (DHS) team members. The team has been asked to eventually cover shifts from 5 AM to 1 AM everyday of the week. An additional 2.3 FTE staff of Outreach Counselor Drivers will eventually be hired in order to complete the coverage on weekends. The team will be based at 39 Fell St., 2nd floor.

The team just recently conducted the first of three planned homeless counts within the targeted area. This mid-day count found 501 individuals who fit the target population. The team also plans to conduct an early morning and night count within the same area. There will be a huge need for mental health and substance abuse services for the homeless individuals that will be outreached by SF HOT. DHS will set-aside both shelter and housing, and respite beds, for these homeless individuals.

3. Behavioral Health Services Integration Consultant. Zialogic has been selected in an RFP process to provide the Behavioral Health Services Integration Consultation to CBHS over a two-year period. The principal Zialogic consultants who will assist CBHS in the process of integrating mental health and substance abuse services are nationally-renowned experts, Christie Cline, M.D., David Mee-Lee, M.D., and Kenneth Minkoff, M.D. Zialogic has extensive experience providing leadership and consultation on integration projects with federal (SAMHSA), state, and county-level behavioral health care systems.

4. Reverse Training: Mental Health Staff Learns About Police Officers. The most recent Police Crisis Intervention Training was conducted last May 3, 2004, which allowed a number of mental health staff to understand more about the training and challenges in a police officer's job. CBHS collaborated with the San Francisco Police Academy to develop this eight-hour training. The training included a Fire Arms Training Simulator, which is an interactive video with a screen depicting actual size people, and presenting scenes for which the trainee must react appropriately or risk simulated harm. There was also a Car Driving Simulator. The training day was spent learning about how and why police are trained to do what they do to keep themselves and the public safe. This ongoing training program has been a huge success in creating greater understanding between the Police and other departments.

5. **02-03 Evaluation Report: High Quality Child Care Mental Health Consultation Initiative.** In its most recent evaluation report (FY 02-03), the High Quality Child Care Mental Health Consultation Initiative demonstrated that children who receive treatment services showed significant increases in their social development and corresponding significant decreases in their clinically problematic behaviors compared to their peers who were not receiving treatment. Evaluation findings also showed very high parent and child-care staff satisfaction with the services because the mental health consultants were viewed as knowledgeable and valuable resources for parenting advice and support.

The High Quality Child Care Mental Health Consultation Initiative is a 5-year Initiative administered by the CBHS Child, Youth and Family System of Care. Funding for this Initiative is from the SF Department of Human Services - Division of Children, Youth and Families, and First Five San Francisco. The Initiative has an annual budget of $2.8M that involves partnership between 10 mental health contractors, 106 center based child care programs, and over 150 family child care homes serving at risk and high risk young children and their families citywide.

The goal of the Initiative is to improve quality of care by providing on-site mental health treatment and prevention services for children, parent education, and consultation services for child care center staff and family child-care providers. This model makes culturally competent services accessible to many children under 5 and their families who would otherwise likely not receive them.

Mental health consultants typically spend 8-10 hours per week at child-care centers. During this time, mental health consultation services can include a wide range of services including case consultation, direct psychotherapeutic intervention with children and families, program consultation, therapeutic play groups, referrals for specialized services (e.g., developmental and learning assessments, occupational therapy, help with Individualized Education Plans, psychotherapy, etc.), parent education and support groups, advocacy for families, and training and support for child care providers. Consultants can thus affect children's mental health and behavioral issues through direct (e.g., psychotherapy) or through indirect means (e.g., working with childcare staff to modify environmental factors, facilitate referrals to other resources, etc.).

Many of the 5,000 plus young children, birth to five, served by the Initiative face very challenging familial and environmental stressors. By placing mental health consultants on-site in these programs, the Department accomplishes a number of important goals. The Initiative services enable families to address mental health issues before their young children start school; consultation services increase the capacity of child care staff to identify and work with families who have emotional, behavioral, and mental health problems; and consultation facilitates early identification of mental health problems among young children in child care. By providing a continuum of mental health consultation services, the Initiative ultimately hopes to improve the overall quality of child care, and increase children's likelihood of succeeding in school.

For more information and to obtain a copy of the report, please contact Dr. Tom Bleecker at 415.642.4515 or tom.bleecker@sfdph.org

6. Employment Exploration for AB2034 Youth Clients. Community Vocational Enterprises (CVE) and the Mobile Support and Treatment Team Homeless Integrated Services Project (MOST AB 2034) recently completed a unique and innovative community-based collaboration that provided paid training and career exploration for MOST AB 2034 youth clients. These clients are between the ages of 18 and 24 and have serious mental illness and histories of homelessness. Many have little or no employment history. The group sessions focused on professional skills required for work. Each session consisted of a visit to a community employer, such as Whole Foods and Burlington Coat Factory, where the clients were provided with a tour of the job site, and educated on the skills and requirements for various job positions. At the completion of each visit, the clients and the group facilitators discussed the professional skills necessary for these positions. The clients were also asked to reflect on their employment strengths and difficulties, and assess the extent to which their interests aligned with the requirements for the various positions.

The sessions were held once a week for 6 weeks. Four participants attended consistently, and all exhibited self-reflection as well as symptom management throughout the group sessions. The groups were facilitated by Rachel Pechter, CVE's Occupational Therapist, Romaine Fike, CVE's Youth Employment Specialist, and Russell Berman, Employment Coordinator of the MOST AB 2034 team. One goal of the collaboration was to familiarize the MOST AB 2034 youth clients with the programs and staff of CVE, so they could pursue services with CVE if desired. This appeared to be very successful, as all of the regular participants expressed interest in pursuing employment through CVE in the future. More information about this collaboration can be obtained by calling Rachel Pechter, CVE Occupational Therapist, at 544-0424 ext. 160, or e-mail rpechter@cve.org.

7. De-escalation Techniques Training for Hotel Staff. After hearing about this ongoing training need, CBHS partnered with the Mental Health Association (MHA) of San Francisco to provide a training on de-escalation techniques and responding to crises for people who work in supportive housing sites. On April 2, 2004, 101 participants including case managers, desk clerks, and property managers who work in supportive housing such as Conard House and DAH housing sites attended the conference.

Michael Arajj, R.N. of the South of market Mental Health Services MOST/AB2034 Team was the trainer. Michael is a certified trainer of Professional Assault Response Training, and has provided a number of trainings for CBHS programs. According to Belinda Lyons, Executive Director of the MHA, there was an "overwhelmingly positive feedback about the training".

The Mental Health Association of San Francisco is a non-profit citizen's organization dedicated to improving the mental health of residents in the diverse communities of San Francisco through advocacy, education, research and service, In all its programs, MHA-SF works together with people and families challenged by mental illness and with the agencies that serve them to promote prevention, access to services, leadership, and independence utilization.

2.0 PUBLIC HEARING CO-SPONSORED WITH SUPERVISOR BEVAN DUFTY ON BEHAVIORAL HEALTH ISSUES WITH CRYSTAL METHAMPHETAMINE ADDICTION

Supervisor Bevan Dufty began the hearing: When I stood out on the street corner campaigning, I was astounded by the number of people who said to me that they had a partner or coworker caught up in crystal meth.

Matthew, who is here from the Bay Area Reporter, has written voluminously about crystal meth. My committee clerk, Mary Red, has worked at the Board of Supervisors for 30 years. We had a 3-hour open hearing with gay men talking about crystal meth. I asked Mary afterwards, how she found it listening to the testimony. She said, "I lost two of my brothers to crack in the 1980's and this hearing is so reminiscent of what I went through."

This is literally a second epidemic. First, there is the HIV epidemic, and now that's being fueled by the crystal meth epidemic. This is a complicated issue with a lot of factors.

I realized when I received David Ibarguen's letter and then he came to see me following the death of his partner, I was touched. David was distressed that neither the police nor Mobile Crisis were able to take his partner to the hospital when he was under the influence of crystal meth. David is not interested in filing a claim against the City, but he wants to look at what we are dealing with and how we are responding to this crisis as a City.

I've been involved in getting more money to cut waiting times at Stonewall and New Leaf. But David also said to me, "If I had known 6 months ago what I know now maybe things could have been different." We need a safe place for people and their partners to come and find out about what to do about crystal meth. I have proposed a national working group on crystal meth.

Now I would like to introduce David Ibarguen. Tonight we want to honor you and your partner.

Mr. Ibarguen: As you know crystal meth has no conscience whatsoever. It steals, it robs, it takes everything. It's only been two months since Neil passed away. I was sitting looking out the window today and thinking about how my home has changed. My spirituality, my closeness, has all changed.

I wanted to go public with this, that he had a psychotic suicide. People want to believe that it wasn't crystal that killed him. In his right frame of mind, Neil would never have killed himself or hurt me or hurt anyone else. He loved people. But in the wrong frame of mind, all he wanted to do was stop the pain. Neil has always had a problem coping with reality.

I want to emphasize the importance of education and teaching people how to cope. Neil was afraid he was never going to work again. He has played all over the country, and all over the world. But he was afraid he wouldn't work again, so he was living in fear.

I probably should have had him committed, or had his family have him committed. Hindsight is 20/20. There are lots of groups out there, like Al-anon and others, but nothing to help people deal with mental psychosis. I want to volunteer myself to talk with people who have been in the same situation that I'm in. I believe that Neil's death was not necessary. There's no crystal ball that says down the road this or that wouldn't have happened. But he was robbed of his life.

What I'm after right now is education to help people make the tough choices.

When the Mobile Crisis Team came out to our family, they slid us a piece of paper with a referral to Stonewall. They didn't ask more questions. They didn't find out what they needed to find out about Neil. They handed him a card and said "Call us if you have a problem." I looked at them and said, "Do you know what it took for me to call the police to have him 5150d and to have Mobile Crisis come out?" I lived with this for a year and a half because I didn't have the courage to get him committed. And I think that it really takes courage to help the people you love.

Mr. Siever: I heard about Neil's death. It's had a huge impact on a lot of people. I'm so sorry for you, David. This is a huge issue. I don't know if there are any easy answers.

Is psychosis driven by the drug or vice versa? Teasing that out is very hard. It's often hard in these situations when people are psychotic and terrified, to know how to help them. People are generally terrified about being taken to Psychiatric Emergency Services.

It's not talked about enough about how crystal meth takes people into psychosis and paranoia, and then it is very hard for them to trust you when you reach out to them.

At Stonewall we field a lot of calls from friends, partners, and lovers. It's a constant juggling act to make room for the people who need treatment and then to help the partners. We're always overbooked. We have drop-in times during the week. We have people at our main site at 18th Street and at the magnet center in the Castro.

Mr. Ibaguen: It was basically shame and not being able to work that was distressing Neil. When he was given the Stonewall referral sheet, he was not given information about other options, perhaps away from San Francisco. He was very famous in our community, and he was afraid he would never work again.

Mr. Siever: Stonewall is a project where people can come to deal with crystal meth. We have drop in times Monday through Friday. We have a drop-in time every Tuesday evening. We try to be as accessible to everyone as we can be. Part of the harm reduction philosophy is that you don't have to be clean and sober to come to the program. We work with people who are still using and are often terrified. And it's really tragic that we as a community have lost a lot of wonderful people because of this drug. I don't know that there is anything easy to do about this. There are clearly not enough resources.

Supervisor Dufty: We're under siege by the Bush Administration, no question about it. They are moving the money to the southeast sector of the City. The CDC has made the determination based on where they think the epidemic is going, which is not what we see in San Francisco. But the Bush administration is not interested in what we need in the Bay Area.

Mr. Luebkeman: A lot of us here have family members with mental illness. We know how hard it is to call the police on a family member. I see it all the time in the community that crystal meth is viewed as an acceptable drug. It's hard to get the message out how easy it is for it to get a hold on you. How do we get the message out? People who wouldn't use heroin find it acceptable to use crystal meth.

Mr. Grier: I'm the Chair of the Treatment on Demand Planing Council, and I'm with the Recovery Theatre. Mental health and substance abuse services need to be partners, but there has never been a national model where that has worked. One has always over shadowed the other.

I wish this story we're hearing tonight was a unique story. We need an environment of intervention which allows the entire community to be educated about using crystal meth. People don't understand how this little bit of powder can produce such disastrous results. They don't understand how long lasting the effects can be. For every mental illness victim and every substance abuse victim there are five other people affected.

We need to embrace you, David, and welcome you and support the cause and rally together. SF needs to rally together whenever there is a crisis. Crystal meth has always been a crisis, but a quiet crisis. We've talked about it for years in Substance Abuse Services. This should not be a mystery.

Mr. Martin: Crystal meth is a drug that has impacted me directly. Michael played a central role in my recovery. It's something ingrained in the San Francisco culture especially. I've never encountered it anywhere in this country like in San Francisco. It is insidious. It becomes part and parcel of the person's persona. The biggest thing we need is make sure people know that crystal meth is a drug that induces psychosis, period. Maybe to different degrees, but it will induce psychoses.

Ms. Shaffer: A recent survey of 1,800 students in the San Francisco schools showed 3% had used methamphetamines.

Supervisor Dufty. That's an excellent point. I'm working with the Schwab Foundation on this. We've identified the dearth of treatment of adolescents and young adults. I'm also working with Larkin Street. I've master-leased a floor of an apartment building to keep our young people in the city. So many young people are getting into spirals of homelessness with crystal meth. The Schwab Foundation is trying to create 200,000 residential treatment beds for youth.

Dr. Cabaj: David, I appreciate your story. It's a personal tragedy for you. But it's one we can all learn from. Thank you, Bevan, for organizing this hearing. Mike, how many

years have we been working on this? Matthew, I've talked to you many times on this issue.

So often risk behavior is associated with drug abuse. I moved here in 1991 from Boston where no one had heard of crystal meth. But on the HIV wards, every man I talked with was using crystal meth. I would ask them, "Has anyone talked with you about crystal meth. And they would answer no. I consulted for 10 years at Larkin Street. What we saw was that first there was a little bit of drug use, then a lot, and then the sexual precautions went out the window.

We recently did a training for our CBHS staff on crystal meth and 200 people attended.

Chance pointed out the issue of psychosis. And also with crystal meth comes aggression, loss of appetite, hyper-vigilance, and paranoia which turns into psychosis,

The number one challenge at PES, is someone who is psychotic in response to drugs. There are treatments. You need hydration and careful observation. Heroin is still by and far the largest cause of medical problems. Crystal meth is right behind as #2 and I think the way it's going, it's going to surpass heroin.

Crystal meth is spreading across the country. It's gotten to the Mississippi, and the South. It's just starting to hit New York and Boston. A couple years ago CDC would have said it's not an issue, but now they are starting to have to pay attention to it.

In many communities, people other than gay men are using, but this is the group with the most serious problems, and then other problems come along as a consequence, like seroconversion, social withdrawal, depression, and crashing. It can lead to cardiac trouble, and deaths are associated with that. There is some evidence that it does permanent brain damage, and especially focusing on parts of the brain that have to do with depression and serotonin levels. So it interferes with the very medicine used for treatment.

There are different patterns of use. People start using it just for the weekend, Friday through Sunday, then crash on Monday. Then some people start daily use.

Mr. Siever: There is a huge amount of variability. Some people get psychotic the first time they use it. Some people have used it 20-30 years without getting psychotic.

An issue for this Board is the need for cross training for clinicians and a lot of education about speed-induced psychosis and other psychoses. I don't care what the cause is, there is a tendency to write it off if it's drug-induced. There are a lot of systemic problems about how we deal with drug and alcohol abuse. I was the first Chair of the Treatment on Demand Planning Council, and have been pushing for years to get all mental health clinicians a better understanding of drug and alcohol issues, and to get all substance abuse staff a better understanding of mental health issues. And primary care issues need to be included, too. In my experience, most physicians haven't a clue about crystal meth.

People need to learn about crystal meth in particular even in substance abuse circles. In some ways it's similar to cocaine and crack and in some ways different. The crack epidemic has never left the African American community. It's still there as bad as ever and it's not in the limelight anymore. It's not okay to get focused on crystal meth and forget about crack and cocaine. I'm a gay man and work primarily in the gay community, but this issue strikes a lot of people in a lot of other communities.

Ms. Brooke: What degree of psychosis, drug-induced or not, warrants a 5150? Family members are very concerned about this.

Dr. Cabaj: This is a tough question. Mike's right. It doesn't matter where the psychosis is coming from. If it's severe enough, the person should be brought in. But psychosis alone doesn't warrant a 5150. Only if it's combined with an inability to care for oneself or with suicidality or paranoia. But suicide is often indirect, a result of trying to get away from the pain.

Colette: Thank you, David, for your courage in coming forth here. At Clients Rights Advocates, we have already started identifying issues around this matter over the past 24 hours. What I've heard here tonight is going to be helpful with the CRA staff. Part of our work is to make sure people with disabilities have access to services, and that their due process rights have been met.

Now that we have moved to the new model of any door is the right door within DPH, I think that's something that has to deeply influence the judgments of evaluators. Even though the state statute reads that you have to be gravely disabled or dangerous to yourself or others as a result of a mental disorder, it is now recognized that self-medication has been something that has been going on with people with psychiatric disabilities forever.

I just hope we start with prevention and education. I would also express my concern that when our clients are brought in for that evaluation at PES, there are some very serious medical issues. I think there needs to be an assessment of mental health's ability to deal with these problems and to provide training that's needed for staff.

People who come in with crystal meth use are at greater risk of dying when they are put in face-down restraints. It's important to make those differential diagnoses. You only need probable cause to bring somebody in. I have been representing people with psychiatric disabilities since 1980. I've represented thousands of people in hearings. The fact is, in the first 72 hours there is generally no due process. Probable cause means only a reasonable suspicion. You don't have to be correct. You just have to exercise good professional judgment and stick to the standards. That's something we need to look at. It is much easier to 5150 someone than is sometimes represented.

I'm not saying it's something we think is terrific. There is a whole group of people who do not want anything to do with the mental health system because they want voluntary services. So we would want to make sure people are dealt with safely and that they get the medical care they need.

Another issue is that if the person is not appropriate for a 5150, they might be appropriate for something else at that point, such as emergency medical care. We want to make sure our Mobile Crisis people are not too much in a box and are able to make appropriate referrals. We have to remember, too, when we call the police and the police come, you are introducing into the situation a potential for morbidity that would not otherwise exist.

So at the CRA we are very concerned that the mental health professionals take care of mental health issues and that the police only take care of real issues of danger. This is one of the great tragedies that the police being made responsible for all they are responsible for at this point. They don't have the training to deal with this kind of thing.

Under the statutes their only responsibility is to transport people to a facility like PES.

We'll be adding crystal meth to the problem codes on our intake forms soon, and will make sure our advocates are properly trained to do intakes and follow ups on this issue.

Please feel free to call me, Colette Hughes, 415-552-8100. It's part of our state mandate to provide technical assistance and information to the public.

Mr. Siever: I think there is a terror of 5150s. If we could figure some other way to do this, people might be willing to go somewhere. PES and 5150s are terrifying to people. For a lot of guys who need help if there were some place else to go they might take advantage of it.

Mr. Luebkeman: What about people with private health insurance, where do they go?

Mr. Sievers: Kaiser has substance abuse treatment. But I hear that it doesn't have a gay focus or a crystal meth focus. There is a tendency to do one size fits all treatment. A lot of gay men tell me Kaiser doesn't work for them.

Mr. Luebkeman: What happens if the crisis comes in the middle of the night?

Mr. Grier: All people do is use the emergency room.

Supervisor Dufty: What David and I have talked about is trying to set up support groups for families. If we could publicize something it might draw more people. Psychologists I have talked with have told me their client base is grappling with this. It wouldn't be hard to find a couple of psychologists who would volunteer to lead this.

Mr. Sievers: Someone years ago started a "Meth Widows Group." It fizzled out. I'd be glad to work on this, but it is funding driven.

Supervisor Dufty: The Metropolitan Community Church was interested in helping with the funding. I'd like the three of us to talk. If we could come up with something, the media would pick it up. I don't think it's that funding driven. I'm committed to doing this.

Mr. Douglas: I did wonder if NA has a family component. Mr. Sievers: There is Crystal Meth Anonymous, which has had a rocky road in this town. They fizzled, but now have restarted. Five days a week there are crystal meth groups, Thursday through Monday. But there is no family component.

mr. martin: We're talking about 5150ing people here. I had the unfortunate experience of being 5150d on Saturday. I was stone cold sober. My partner called Mobile Crisis who could not respond, so she called 9-1-1. Ten San Francisco police showed up in my apartment. One had an assault rifle. And my partner had clearly stated that there were no weapons in the house and that I was not acting out violently.

I was taken to PES, and I'm the kind of person who makes lemonade out of lemons, so I thought it was a chance for a site visit, because I did not feel I needed to be there. I was identified as a mental patient. PES is tragically understaffed.

I was there 13 hours. There were hours-long stretches when I was left unattended and unsupervised on a gurney in a hall when I could have done any number of things to hurt myself. I could have drunk the fermenting milk that was on the floor. One nurse was actively hostile to patients, mocking their symptoms. One woman who was psychotic, slapped a psych tech's glasses from his face and was put back in seclusion. The nurse doing the primary triage, harangued this psych tech into filing charges so this woman would be treated at county jail instead of PES.

It would certainly appear that this is another reason why we need to expand the Mobile Crisis Treatment Team to 24/7. I don't know what good this Police Crisis Intervention Training is doing. I understand that there is a lot of tension in the Police Department right now. But that does not give them license to endanger the public. I did nothing to warrant having an assault rifle in my presence.

This nurse was atrocious and I understand what it is to work in an understaffed facility. I think the understaffing is the major factor in the behavior of the staff I saw there.

I'm sorry to say, "Yes, it's a good thing to have the courage to call the police when a loved one needs help, but there are still major problems with our emergency system.

Mr. Smith: My name is Beau Smith, and I'm with the Morris Center for Adult Survivors of Child Abuse. I can empathize with what David was talking about and the lack of courage, having watched a loved one deteriorate and not having the support to get help. We need to have support teams for partners. I'm also a recovered alcoholic and I can't tell you how many families I've seen that they just watch their loved ones deteriorate. There's that lack of courage to be able to intervene. My question to the community is: Can we focus on supporting intervention and educating on how to intervene?

Mr. Webber: My name is John Webber, and I'm the ILRC, Benefits Coordinator. Basically I assist anyone in the City receiving any disability payments to get back to work. I want to express serious concern, and I want to thank Bevan for championing this issue. It took a great amount of courage to do what you are doing right now, David, and I want to express love to you. I'm part of the African American community, the

poor community, and the disability community. These communities have been ravaged by this drug problem. In San Francisco we often wait until things reach an epidemic proportion before we take action.

Bevan when you say we're hemorrhaging with these health care cuts and educational cuts, I 'd like to see us explore these things right now:

1. Youth within the School District: They have cut out the transition department for youth. There is no support system when youth come to the city. When youth first come to the city, they should receive an information packet about the things they need to be aware of and about resources.

2. Why aren't we more proactive? Why do we have to wait for a crisis?

3. We're solving the issue now for adults. I see young gay men and women and they come up to me and put their arms around me. There are now a huge number of young people using meth right now. We need a serious aggressive approach to the youth. Not just educating them, but resolving the issue.

Ms. Farrell: We have a view of crystal meth, too, because Ohlhoff has been working with gay men and straight children, usually young women. There's a component to crystal meth, not just a partying image, but a body image thing, to be that thin person, and there's a nutritional side to it. But as we've been treating more and more people, and as we talk about risky sexual behavior, we find people who have never had sex without taking the drug. They are terrified to give up the drug. They don't know how to do sex without the drug.

We are a resource. If you are worried about somebody, call us. We have 30-40% gay clients. We will go and speak in the community at any meeting. I have gay and lesbian staff in all my programs, and I'm grateful for that. It's something we have worked very hard to establish.

Dr. Turner: What about youth? Ms. Farrell: Yes, we have a program for young people, but it's not residential.

Mr. Stinson: Thank you to everyone who participated tonight, and especially David.

Mr. Ibarguen: Many of the times that this happened in the year and a half previously, Neil's addiction problem and when he was crazed was always late at night, so getting phone calls through to Ohlhoff or Mobile Crisis doesn't work. He's crazy right now in the middle of the night. Tomorrow he's going to be okay.

It's all self preservation on their part. They challenge you when it's late at night, when there is very little access. Can't there be some kind of hotline where people like myself and family members could call at any hour and get some kind of critical help, especially in the middle of the night.

Ms. Farrell: The National Council has a 24-hour helpline.

Mr. Stinson: One of the MHB priorities for this year is making Mobile Crisis 24/7 and having a 24/7 Drop-in Center.

Ms. Kellum-King: My heart goes out to you, David. Something Carol and I have recently done is going through teacher training in order to work with family members of those with mental illness. Now we teach a twelve week course for family members. When it comes from the heart it goes to the heart. Sometime when you are healed you can take the lead on this.

Mr. Ibarguen: I'm doing that.

Mr. Luebkeman: When my sister was going through her severe psychosis, she got great treatment and that's the only reason she's alive. She had a great psychiatrist who called us together and said, "You family members are going to make the difference." She taught us key words. Chance, Thank you for sharing your experience with us tonight.

4.0 MENTAL HEALTH BOARD COMMITTEES

Ms. Brooke: We've scheduled our Mental Health Board Annual Reception for July 15th from 4-6 p.m. at City Hall.

Mr. Stinson: I want to thank Kevin McGirr for helping to get many of the speakers for tonight's meeting.

Toye and I had a meeting with the Mayor two weeks ago. He gave us 25 minutes of his time which we thought was very generous. I want to say a big thank you to Kevin McGirr, Bill McConnell, and Erin Pirkle who helped with a lot of the data for our presentation to the Mayor.

> **RESOLUTION (MHB-2004-19): Be it resolved that the minutes of the Mental Health Board meeting of April 14, 2004 be approved as submitted with corrections from Dorothy Shaffer. (Passed unanimously.)**
>
> **RESOLUTION (MHB-2004-20): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 12, 2004, to the following members: Toye Moses, Kate Walker, Sandy Yuen, Dennis Yun (Passed unanimously.)**

The resolution on the budget will be tabled until the next meeting.

5.0 NEW BUSINESS

Mr. Luebkeman: Jeff Adachi would be interested in coming to the Board to talk about the Behavioral Health Courts.

mr. martin: There's a rally tomorrow at 5 p.m. at the Pacific Stock Exchange against health employees taking a 7.5% pay cut while downtown businesses are evading taxes.

I would like to ask PES to come and give us a presentation.

Ms. Shaffer: I'd like a presentation from the Campaign for Mental Health.

6.0 PUBLIC COMMENTS

Ms. Spanglet: I'm a former Family Member of the Mental Health Board. Mickey and I were at a meeting on Saturday regarding the mental health initiative. It is extremely important that this initiative pass in November. There's going to be a lot of talk about taxes. The minute people hear about taxes they are going to vote no. People need to know that it is one cent per dollar for dollars over one million dollars. Chat this up with your friends and family and make sure people vote for it.

Mr. Stinson: I absolutely agree that this is very, very important. The website is: www.campaignformentalhealth.org.

Ms. Spanglet: I had to have my daughter 5150d. Without a doubt it was the hardest thing I ever had to do in my life. It was the only way I knew how to help her. If you love someone you just really and truly have to gather up the courage and do it. I think it was harder on me than it was on my daughter.

7.0 ADJOURNMENT

There being no further business, the meeting was adjourned at 9:04 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, June 9, 2004
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of May 12, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of June 9, 2004, to the following members: Dennis Yun

2.0 WOMEN'S MENTAL HEALTH ISSUES (45 minutes)

Maria Cora, Director of Women's Health for the Department of Public Health will present about overall mental health issues for women. Elayne Doughty will speak about a revolutionary treatment strategy for women with mental health and substance abuse issues.

2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

3.0 DIRECTORS REPORTS (25 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.
Discussion of budget policy and strategy.

4.1.a PROPOSED RESOLUTION: Regarding the budget for Community Behavioral Health Services, thanking the Mayor for saving so many services, and urging the City to do everything in its power to protect all services now and into the future. (Attachment A)

4.1.b PROPOSED RESOLUTION: Regarding the crisis in the use of crystal methamphetamine in San Francisco and the City's response to this crisis. (Attachment B)

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

7.0 ADJOURNMENT

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

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Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: **www.sfgov.org/sunshine.htm**

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MENTAL HEALTH BOARD
ATTACHMENT A
June 9, 2004

PROPOSED RESOLUTION (MHB-2004-xx): SAN FRANCISCO'S BUDGET CRISIS

Part I

WHEREAS, Mayor Gavin Newsom in his first months in office has faced the largest deficit in the history of San Francisco, and

WHEREAS, Mayor Newsom has protected services that provide crucial help to the most needy residents of our city, and

WHEREAS, within Community Behavioral Health Services, the Mayor has protected programs which provide substance abuse services, along with both community-based nonprofits and Civil Service programs which provide mental health services, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco commends Mayor Newsom for his personal, thoughtful, and strategic attention to the budgets of the City departments, on a program by program and line by line basis, a level of attention which is very uncommon for the mayor of a major American city, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco thanks Mayor Newsom for his courage in taking a stand to continue funding as many services as possible for the City's residents most in need, and for protecting the City's long-term investment in residential care facilities and other irreplaceable programs.

Part II

WHEREAS, the cuts slated for Community Behavioral Health Services beyond the programs protected by the Mayor are still serious and cause for deep concern, and

WHEREAS, the current fiscal crisis threatens to continue beyond fiscal year 04/05, on into the next two to three years, and

WHEREAS, public health services could face devastating cuts as a result; and

WHEREAS, with regard to mental health services, the Bronzan-McCorquodale Act of 1991 (Section 5600 and following in the State Welfare and Institutions Code) outlines a complete system of care as the most effective and cost-efficient way to provide services and mandates that Counties to the best of their ability provide a comprehensive system of services, and

WHEREAS, in San Francisco, Community Behavioral Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, which meets the Bronzan-McCorquodale guidelines, and whereas, cuts will fragment that system and damage its cost effectiveness strategies, and

WHEREAS, a severe cut would mean that many clients of the mental health system who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, inpatient units at San Francisco General Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save, and

WHEREAS, the Mental Health Board further believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to respond to this crisis during the next years with a comprehensive revenue strategy, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the art services the city has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the sustainability of the community-based nonprofit organizations which deliver such a large percentage of its public health services, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured working citizens, and

BE IT FURTHER RESOLVED, in summary, that San Francisco be a role model and deliver a message to our nation about the importance of protecting our infrastructure and protecting all of our residents, even, or especially, during a time of international crisis and danger, and that we not end up losing the very things we are seeking to defend.

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MENTAL HEALTH BOARD
ATTACHMENT B
June 9, 2004

PROPOSED RESOLUTION (MHB-2004-xx): RESPONDING TO THE CRYSTAL METHAMPHETAMINE CRISIS IN SAN FRANCISCO

The Mental Health Board of San Francisco wishes to commend David Ibarguen for his courage in bringing the issue of crystal methamphetamine to the Board and emphasizing the magnitude of the crisis that currently exists with the abuse of this drug in San Francisco.

In Mr. Ibarguen's words, "Crystal meth has no conscience whatsoever. It steals, it robs, it takes everything."

The Mental Health Board wishes to commend Supervisor Bevan Dufty for asking the Board to co-sponsor a public hearing with him on May 12, 2004, on the issue of crystal methamphetamine and the damage it is currently doing to individual residents of San Francisco, their loved ones, and the community at large.

In response to this hearing, the Mental Health Board now resolves to recommend the following to the City and County of San Francisco:

1. That Community Behavioral Health Services (CBHS) provide and promote groups for partners, spouses, family, and friends, to give them the support they need and the strategies they need to cope with their loved ones and to intervene with them.

2. That CBHS continue to provide trainings as needed on assessing and treating crystal methamphetamine abuse and addiction and that these trainings be provided for all relevant staff, but especially for mental health clinicians and primary care clinicians within the Department of Public Health.

3. That the City do an assessment of the level of use of crystal methamphetamine in San Francisco, looking at what motivates its use, what particular groups are most impacted by it, and what would be the most effective prevention and intervention strategies.

4. That the City design specific treatment responses to meet the needs of different groups within San Francisco, including the gay community, the African American community, and youth.

5. That the City design and promote a public education campaign to make people aware of the dangers of crystal methamphetamine, to let people know where to call or go for help, and to help prevent people, especially young people, from ever getting started on this drug.

Finally, the Mental Health Board would like to pass this resolution in memory of Neil Lewis and the many, many other San Franciscans whose lives have been destroyed by crystal methamphetamine.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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UNADOPTED MINUTES
Mental Health Board
Wednesday, June 9, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Augusta Del Zotto, Ph.D. (Acting Chair); Bridgett Brown; Bob Douglas, J.D.; LaVaughn Kellum-King, Carol Knight, M.A.; Joel Luebkeman; chance martin; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.; Kate Walker; Idell Wilson.

BOARD MEMBERS ON LEAVE: Supervisor Bevan Dufty; Toye Moses, Ph.D., M.P.H.; Ted Stinson (Chair); Sandy Yuen; Dennis Yun, M.S.W.

BOARD MEMBERS ABSENT: none

PRESENTERS:
Maria Cora, Coordinator of the Office Women's Health, Department of Public Health
Elayne Doughty, MFT, Treatment Supervisor, Women's Recovery Association, Burlingame

OTHERS PRESENT: Robert Cabaj (Community Behavioral Health Services); Edwin Batongbacal (CBHS); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR

There was no quorum at the beginning of the meeting. The presentation began at 6:45. A quorum was reached during the presentation, so the Consent Calendar was brought to a vote following the presentation.

2.0 WOMEN'S MENTAL HEALTH ISSUES

Ms. Cora: I'm the Coordinator for the Office of Women's Health in the Department of Public Health. Thank you for inviting me. And thank you for picking women's issues as one of your priorities for this year. I look forward to working with you in any way I can.

The DPH Women's Health Plan was issued in 2003 and is on the DPH website.

Status of Women's Mental Health

The SFDPH Women's Health Plan issued in May of 2003 briefly describes some of the characteristics of the mental health of women and girls. Research has found mental disorders affect women and men almost equally, however certain disorders affect women much more commonly than men. Women are twice as likely as men to experience depression, and two to three times as likely to experience anxiety disorders, such as panic, phobias, and posttraumatic stress. Women are also far more likely to experience anorexia and bulimia. Eating disorders, 90 percent of which involve adolescent or young adult women, cause more deaths than any other mental disorder. The leading cause of years lived with a disabling condition among women in San Francisco in 2000 was unipolar depressive disorder. Gender-specific differences in levels of neurotransmitters have been used to explain the difference in the incidence of depression, which is twice as high in women as in men in virtually every country in the world. Incidence and prevalence rates for Alzheimer's disease are higher in women than in men. Alzheimer's disease is a problem for more women than for men—as both patients and caregivers. Violence and poverty also disproportionately affect women and contribute to increasing needs for mental health services for women.

California Realities

The Women's Mental Health Policy Council, an advocacy and research organization focused on improving mental health services for women and girls in California, hosted a briefing on women's mental health issues in Sacramento in January 2004 entitled "Gender Matters: Promoting Mental Health for Girls and Women." One of the presentations presented data documenting differences between women and men in the utilization of mental health services in California. Most notably, females under age 40 are less likely than males to receive mental health services. Analysis of the data in this report reveals that this finding is consistent for the Medi-Cal population, the population served through the Chapter 26.5 Special Education mandate and the public mental health population as a whole. In FY 00/01, among Medi-Cal mental health clients under 60 years of age served in the public mental health system, the average cost per client across all services, including both inpatient and outpatient services, was lower for women than for men. Additionally, female clients are less likely than males to receive medication support services.

For ages 0-17, 18-20 and 21-39, proportionately fewer females access mental health services. Females ages 60+ have a higher access rate. This low pattern of mental health access is of particular concern for women ages 18-39 because rates of serious depression in women are highest during the child-bearing years and are double that of men. Factors that may account for the lower access rates for girls and young women include that agencies such as schools, juvenile justice systems and child welfare systems refer many more boys than girls for mental health services. Also, girls tend to have more internalizing disorders, such as depression, while boys tend to have more externalizing disorders such as ADHD and disruptive behavior disorders.

The CWMHPC report points to the alarming lack of gender-based data available. "Critical data on the multiple roles women play in society is missing. The state has no data on the caregiving roles and responsibilities of women in the public mental health

system. Integrated data is not available that provides information on mental health issues for women and girls across systems, such as substance abuse, primary care, domestic violence, child welfare, CalWORKs, education, and juvenile justice. Data within these other systems are often not presented by gender and are not integrated with mental health data, preventing advocates and policy makers from relating data across systems." Without this data, the specificity of women's mental health needs remain invisible.

Other presentations at the CWMHPC briefing highlighted that women's mental health is marked by ethnic differences that must be taken into account when designing services. Some of these were:

> Black women are less likely to seek and receive mental health care and share a historical fear and distrust of mental health treatment. 60% of Black women have symptoms of depression and their mental health is disproportionately impacted by violence, racism and economic insecurity.
>
> Asian American women have high rates of depression, especially young women. They suffer from stigma, low self esteem and are impacted by cultural barriers; these factors contribute to high levels of depression and suicide.
>
> Latina girls lead girls nationally in alarming rates of suicide, and alcohol and drug abuse. Depression is a prevalent threat to their health.
>
> Other factors in women' lives which require our attention include the cumulative impact of physical and sexual trauma and violence on women's mental health and the impact of homophobia, heterosexism, ageism and ableism on the mental health of certain vulnerable populations of women.

San Francisco Dept. of Public Health Mental Health Services for Women

The SFDPH provides integrated mental health and substance abuse services through the Community Behavioral Health Services. The CBHS operates the San Francisco Mental Health Plan; this plan strives to provide services that are high quality, effective, cost-efficient, community based, culturally competent and consumer guided. Mental health services are also provided by SFDPH to incarcerated women and girls detained at Youth Guidance Center through Jail Health Services and Special Programs for Youth.

The top leading cause of Disability Adjusted Life Years (DALYs — a combination of years lost to premature mortality and years lived with a disabling condition) among women in San Francisco in 2000 was Unipolar Depressive Disorder. The fourth cause of DALYs among SF women was Alzheimer's Disease and other Dementias and the sixth cause was Alcohol Use Disorder. The ten most frequent primary discharge diagnosis for women for inpatient services at SFGH in FY 01'-02' included Psychosis, Schizophrenia and Depressive Disorder.

The SFDPH in the last 3 years has provided more mental health services to men than to women although the population of San Francisco is 49.2% female.

In 00'-01', of a total of 20,961 clients served, 44% were female and 55% were male.
In 01'-02', of a total of 21,424 clients served, 45% were female and 55% were male.
In 02'-03', of a total of 22,480 clients served, 45% were female and 55% were male.

The trend of more men accessing services is consistent across modes of treatment.

Day Treatment and Socialization: 00'-01' (1,741 F, 2,803 M), 01'-02' (1,787 F, 2,810 M), 02'-03' (1,760 F, 2,836 M)
Inpatient: 00'-01' (1,088 F, 1,659 M), 01'-02' (1,049 F, 1,556 M), 02'-03' (1,062 F, 1,586 M)
Outpatient: 00'-01' (8,721 F, 10,404 M), 01'-02' (8,720 F, 9,922 M), 02'-03' (9,367 F, 11,144 M)

The SFMHP provides mental health services through institutions, Organizational Providers and the Private Provider Network. The top ten programs providing mental health services to female clients ages 18 and over in FY 02'-03' were:

SFGH Psychiatric Crisis Stabilization (1,336 clients)
Chinatown North Beach OP (776 clients)
Richmond Area Maxi Center OP (603 clients)
Westside Community Crisis Clinic (584 clients)
Mission Mental Health Team I (566 clients)
LPS Conservatorship (518 clients)
Sunset Mental Health Center OP (506 clients)
South of Market Outpatient (409 clients)
Mobile Crisis Treatment Team (289 clients)
SFGH Ward 7A (283 clients)

Concerning gender differences in access rates to medication support services, the DPH Community Mental Health Services (now part of CBHS) provided medication support services as follows:

FY 00'-01': 44% of total clients — F 46%, M 43%
FY 01'-02': 55% of total clients — F 56%, M 55%
FY 02'-03': 55% of total clients — F 55%, M 56%

Thumbnail sketches of CBHS contractor programs. Two programs stand out with services for women:

A. Hyde Street Community Services offers two mental health programs for the San Francisco community:

The Tenderloin Outpatient Clinic offers a full range of services including: intensive case management, outreach, medication, assessment, individual and group therapy, urgent care, dual diagnosis focus and homeless focus. They serve 700 unduplicated clients per year of which roughly 40% are women. They facilitate a women's therapy

group and a women of color therapy group. 60% of the women served suffer with PTSD and most are dealing with multiple losses in their lives including the loss of their children.

The San Francisco Community Clubhouse serves as a place encouraging of increasing independence and self-reliance. It is a 'Wellness and Recovery Center' day program emphasizing peer support offering pre-vocational, socialization and recreational activities for people with chronic mental disorders who have achieved a level of stabilization. It also serves a client base of roughly 40% women.

B. Iris Center : Woman's Counseling and Recovery Services provides counseling and mental health services, HIV services and drug and alcohol recovery services to women 18 years and older. They particularly focus on women of color, single mothers and lesbians.

DPH Office of Women's Health Activities

Women's Access to Treatment Committee: Staff attends monthly meetings of provider group focusing on the phenomenon of women accessing services and treatment in decreasing numbers. Issues being examined by this group include: safety issues faced by women as services become predominantly male, the raising of the threshold for acuity, the higher standard for 5150 and conservatorship in SF County, additional difficulty of women with children accessing treatment.

Lesbian Health Research Center: Staff is member of Executive Council and is founding member of the Black Lesbian Health Research Project. Provided expertise in organizing of upcoming CBHS Conference "Current Challenges in Lesbian Mental Health."

Women and Girls Health Advisory Committee and Young Women's Health Task Force: Staff provides staff support to DPH sponsored community advisory groups.

Community Advisory Council for SFGH Breast Care Program: Staff is member and attends monthly meetings.

Cultural Competency Task Force: Staff is member of DPH committee and attends monthly meetings.

Special Programs for Youth: Staff provides health education services to young women detained at Youth Guidance Center and is assisting in revamping of provision of mental health services.

Women's Health Plan: Staff is assisting DPH in implementing strategic plan for women and girls health services.

Prevention Strategic Plan Workgroup: Staff is currently participating in DPH implementation efforts. Depression and cardiovascular disease were selected as health outcomes to impact; low socio-economic status, social

connectedness/isolation, institutional racism, and transport systems were the social determinants of health selected to impact.

Thanks to Nick Hancock who put the numbers together for this report.

Ms. Shaffer: With regard to the data problem you mentioned, you need this information to make decisions about services. What can CBHS do to help streamline this data collection and make it complete? How we can support you?

Ms. Cora: In terms of recommendations to the Department, it could be recommended that all programs, including contractors, maintain gender specific data, including details about what the services are. For example, with regard to the Provider Manual, if I were a woman looking for gender specific services, I'd have a hard time finding them. You'd have to read through every program description. The Manual could be made a little more woman-friendly.

Ms. Walker: How do you get access for a woman-friendly program?

Ms. Cora: Once you call the central number, and tell them "I am a woman who needs women's services," the referral person is supposed to have the expertise to guide you to the right program. It would be great if there were more gender specific programs.

Dr. Del Zotto: As a former client and now as someone who provides services to clients, I want to emphasize that one big fear women have is that if you ask for help, they'll take your children away from you.

Ms. Cora: The Committee is studying that fear as one of the reasons why women don't access services. Also, many programs won't take women with kids.

Ms. Knight: How will the current budget cuts affect programs for women?

Mr. Cora: That's a complex question. The cuts have eliminated many staff at the DPH administrative level and this requites the rrest of the staff to step up to perform additional tasks. For example, I'm working on a project improving services at Youth Guidance Center, and I'm glad to do that, but it gives me less time to work on gender-specific services. We don't know the final outcome of the budget yet. The budget will still to go to the Board of Supervisors and they can do addbacks. So we're waiting until September to find out what we have left to work with.

I'm somewhat limited in what I do, because the Office of Women's Health does not have other staff, and it's quite a challenge working on women's health by myself, given how huge the Public Health Department is.

Ms. Shaffer: You talked about medications as a treatment. Are you following other treatment modalities for gender differences? Ms. Cora: Not specifically at this time, but this would be interesting data to collect provider by provider. One suggestion would be to check the numbers for women in the client satisfactino surveys. Dr. Turner: I think we need to look at that. It's important for us.

Ms. Wilson: What is the Women's Access Committee?

Ms. Wilson: What is the Women's Access Committee?

Ms. Cora: It was called together by Progress Foundation, and is relatively new. It's made up of mental health providers and some substance abuse providers. They are concerned about the reduction of women's access to treatment. It looks like it's turning out to be a complex issue. There are factors like safety, the rising threshold for acuity, the higher 5150 standard, and the difficulty of women with children accessing treatment.

We're collecting data from many sites, trying to see what the answer is. We're looking at where women are going if they are not accessing treatment. Are they just suffering? Is it the squeaky wheel gets access and men are better at getting the attention?

Dr. Turner: I thought all the therapy data showed that women seek mental health services more than men.

Ms. Cora: That has changed. There's much more to explore. The Committee is trying to figure this out.

Elayne Doughty then presented as follows: Thank you to Maria for laying the ground work so fabulously. Her data is what I work with every day in the field.

I'm the Treatment Supervisor for the Women's Recovery Association in Burlingame. I'm in private practice in San Francisco, and I consult with agencies throughout the Bay Area on creating gender-responsive treatment.

I've been working in gender-specific services with women for the past 7 years. My passion is providing services for women.

In the recovery program where I work, the women are mostly dually-diagnosed if not triply-diagnosed. So we don't separate out mental health and substance abuse services.

The number one glaring thing in research on recovery for women in mental health is that women tend to do better in women-only treatment, and men tend to do better in co-ed treatment. Why is that? Women tend to have more interpersonal and relating skills, so they do better when they are with each other, and those skills are helpful to the men when they are in co-ed programs.

Many women are scared to be in treatment with men. So many have a history of abuse, often related to a man. Bringing her into a setting where there are so many triggers for abuse memories when she is trying to deal with the abuse doesn't work so well.

Women are less likely now to seek treatment, in part because a lot of the services were originally developed to treat men. Women are more likely to remain abstinent with regard to drugs after treatment than men. They are more likely to remain healthy.

Men and women have different motivations for taking drugs, and they use different drugs.

With regard to the theory and research about what works for women:

> Women do best with a model of treatment that is a strength-based model. It addresses raising the women's sense of self-esteem and agency in the world. Women do much better where they can build relationships with other women, and when they can attend an alumnae group following treatment so they can stay in touch. Women do worse when they get isolated.
>
> Key words for women's programs are: mutuality, empathy, respect, and relational focus.
>
> Women need treatment that is holistic, in context of their issues of violence, trauma, parenting, and housing. We need to provide treatment in the context of all these factors having to do with her life.

In my own work, I have been part of a team of clinicians to provide gender-responsive program. We've developed programs in alliance with clients, in a collaborative model. And this is a model that works well for women.

My own part has been leading a group called "Recovering Womanhood," which helps women reconnect to caring for themselves and re-educating them on caring about their bodies. They learn about their menstrual cycles and their moods and how they impact how they are doing. Women are much more likely to relapse when in they are in the premenstrual part of their cycle. Do they know this? No. We're working to educate them. The women learn to track their cycles, and make decisions based on where they are in their cycles.

This tracking also helps them pay attention to when they are fertile and likely to get pregnant. This can cut down on the number of abortions or unwanted kids they have. They are able to take more responsibility when they know more about their bodies. With men in the room it, would be hard for women to discuss this information openly.

We work on sexuality issues, and for women with abuse histories, it's very hard to talk about those things in a mixed gender group. These issues are very important to women in terms of healing.

What works for women:

> Gender specific groups. I work with groups of 35 and then divide the larger group into smaller groups of 9 for processing. But the big group builds a sense of community.
>
> Create an environment that fosters safety, respect, and dignity. You're not coming to me for me to give you your treatment. We'll be partners in your treatment.
>
> Assessing strengths and building on them.

There are very few places that offer women-only treatment. We need two types of groups: process groups and psycho-educational groups.

This isn't to say that co-ed treatment doesn't work. It seems that later on in the woman's recovery, it can help to have co-ed groups when women are ready to work on their relational skills with men. After all they are going to have to go back out into the world which is half men.

We need to recognize that there are differences between women, and that different women may require different styles of treatment.

It's important to see women as individuals within the context of gender-specific treatment.

There also needs to be childcare. Where I work, we have that, but can only take six women on that basis. And we're the only such program in San Mateo County.

Women often need education and primary treatment for PTSD. In the past, they said you can't treat women for PTSD until they are stabilized. But the problem is they can't stabilize until they start working on their PTSD.

What happens after the women graduate from the program? They can come back and mentor other clients. Keeping that web of community alive works really well for women.

Ms. Brown: What is the substance of choice for women?

Ms. Doughty: It used to be alcohol and painkillers. We still see lots of painkillers. But now we see poly-abuse, meaning that women are using multiple drugs. This cuts across social strata, too.

Mr. Douglas: If you were doing the intakes for the mental health system, how would you identify women who need women-specific programs?

Ms. Doughty: I think most women could use a gender-specific group, but especially if they have a history of abuse or PTSD. In that case, a woman in the initial stages of recovery is going to do much better in a woman-only program or where she has access to women's groups.

Ms. Kellum-King: How many women come back to be part of the mentoring program?

Ms. Doughty: In my program, 65% of the women come back in a variety of roles.

Ms. Brooke: Edwin, is DPH working with Maria and consultants like Elayne to make sure that we are increasing the number of gender-specific programs? The Department is going through big changes, so this could be the perfect time to add more women-only groups.

Mr. Batongbacal: This has not been the focus of attention in the current changes.

Ms. Brooke: Will you take this back to DPH?

Mr. Batongbacal: Yes, the presentations tonight have been educational for me. I don't think we are doing enough.

Ms. Shaffer: This is an issue of cost-effectiveness, too. Getting the right treatment is more cost-efficient.

Ms. Doughty: Women-only groups are a hook for a lot of women to come into treatment. Otherwise women might be too scared.

Mr. Beau Smith: I'm from the Morris Center for Adult Survivors of Child Abuse. I wanted to know if you have any statistics on the trauma that creates the PTSD? I'm assuming it's childhood abuse.

Ms. Doughty: I can send you what we've collected at our center. I would say it's a high percentage of women with PTSD who are recovering from childhood sexual abuse.

Ms. Cora: From the DPH perspective, we don't have that data in a central way. It would mean going through charts to find the cause.

Beau Smith: Do you feel you have enough support groups, and self-help groups? It seems like there are lots of 12-step programs around, but none specifically for childhood abuse.

Ms. Doughty: No, we don't have enough groups, especially groups that are free of charge.

Ms. Doughty: There is some beginning recognition of supporting self-help recovery communities. These have been long established in substance abuse services. In mental health, there is an emerging understanding of the unique power of peers supporting each other. The mental health community needs more such groups.

Mr. Bantongbacal: We're making a modest effort in that direction. We have a commitment to support self-help programs like Oasis Community Center and Spiritmenders.

Ms. Cora: The Community Club House seems to be the model of peer support.

Ms. Doughty: The model of peer support and longevity of connection that works well for substance abuse services actually works for mental health services as well.

Dr. Turner: There's a tremendous amount of scientific evidence that social support makes a tremendous difference for people, including for physical health issues, too.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services
Edwin Batongbacal reporting for Dr. Robert Cabaj: A week and a half ago the Mayor decided to restore funding for Sunset Mental Health, Mission Mental Health, Mission ACT, and Central City Seniors. This is very good news. It highlights the importance and unpredictability of the political process. Advocates came out and said, "These cuts are not workable. We need to look at the longer term impact."

In public health as a whole, 340 civil service positions are being cut. Of those positions, 190 had people in them and the rest were vacant positions.

All of the secretarial positions in CBHS are gone. This means we will be losing very good people, many of whom have been with us for a long time. Senior Social Worker positions have also been cut. Ultimately the administrative office needs to do the same work with fewer staff.

There will be an advocacy day in Sacramento on May 27th.

The Mental Health Services Act will be on the ballot in November. For San Francisco, it could mean that we'd get $50 million a year. If it passes, the money will start coming in fiscal year 05/06. That represents about a third of our budget. Polls say so far it's receiving 67% support.

Ms. Knight: Was there any reason why Southeast Mission Geriatrics was not including in the restoration?

Mr. Batongbacal: That's a good question. The story is not over. There are advocates trying to restore it. The proposal is to move it to the OMI Mental Health Clinic to save administrative costs and rent, but the negative effect would be disruption of care plans and accessibility.

Ms. Knight: I was at Southeast Mission Geriatrics to meet with clients and to speak to the group. They are elderly clients who would have a hard time getting to OMI. And the parking situation is not good at OMI. You're going to lose a lot of elderly clients who are there now.

The low salary on management positions is $89,000 and goes up to $170,000. Some of that money could be used to keep mental health services open.

Mr. Bantongbacal: Administration has taken a severe hit over the past three years, we're having to pick up the work of a lot of positions.

Mr. Douglas: Is Team II moving to Castro Mission?

Mr. Bantongbacal: That's not decided. There's talk about moving to OMI and Castro Mission both. Also advocates trying to keep them where they are. The ideal would be staying where they are. But the budget and political process will determine what happens.

Mr. Kalman: I have the Mayor's Budget here. Could you tell me where the MHRF budget is in this document? How are things with the MHRF? I have heard some negative depressing news.

Mr. Batongbacal: There is a blue ribbon commission working on the MHRF. They are proposing 3-4 different licenses: The 3rd floor would have a mental health rehabilitation license. The 2nd floor would have a skilled nursing facility license, which is the current license for most of the MHRF. The 1st floor would be a combination of residential care facility, community care licensing, and a residential treatment program.

Mr. Kalman: Will they be City jobs? Mr. Batongbacal: As far as I know they will be City jobs.

The written Director's Report was distributed:

1. CBHS Mental Health Programs Restored in the 04-05 Budget. Mayor Newsom has announced that he will fully fund Mission Assertive Community Treatment, Mission Mental Health Services, Sunset Mental Health Clinic, and Central City Older Adults Clinic. DPH's contingency budget originally proposed consolidating these programs into primary care centers. However, consistent with the contingency budget resolution the Health Commission passed early last month, the Mayor's office further considered the specific impact of mental health services in the Mission and was able to find the revenues necessary to maintain these services, as well as those at Sunset Mental Health Services and Older Adult Services.

2. Mental Health Advocacy Day in Sacramento. Fifty-six San Francisco clients, and nine advocates and mental health workers, converged on the steps of Capitol Mall in Sacramento on May 27, Mental Health Advocacy Day. Joining thousands of other clients and advocates from across California, they rallied to our California legislators for "No cuts to mental health services," and expressed support for the upcoming campaign for the California Mental Health Initiative that will increase funds for mental health services if passed by the voters of California in the November ballot.

3. CBHS Cultural Competence Plan Update. I am pleased to report that the 2003 San Francisco CBHS Cultural Competence Plan Update, a mandate for county mental health programs, received a high 97% score from the California Department of Mental Health. The Plan reported on San Francisco CBHS' Cultural Competence activities, progress, challenges and changes since July 1, 2002, that have helped CBHS move toward meeting DMH's Culturally and Linguistically Appropriate Services Standards (CLAS). The update has five key sections: population assessment and analysis, human resources analysis, training, select requirements/ quality improvement, and challenges/recommendations. It also reported on the integration of mental health and substance abuse services in which cultural competence has been identified as a key functional element in planning and implementation. The report requires information on our mental health Medi-Cal population, which is approximately 65% of our mental health clientele. However, as CBHS provides a single standard of care, information on all 21,810 (FY 01-02) of indigent clients served was also included. For a report e-mailed

to you, please contact Genie Wong at HYPERLINK "mailto:Genie.Wong@sfdph.org" or call 255-3426.

4. Dialectical Behavioral Therapy. In fiscal year 2002-03, CBHS launched a training program in Dialectical Behavioral Therapy (DBT), an evidence based practice developed by Marcia Linehan, Ph.D. This approach has been effective in treating individuals who are diagnosed with Borderline Personality Disorder (BPD). Individuals with BPD have among the highest lifetime prevalence of completed suicide. Due to suicidal and severe acting out behaviors, they utilize acute services and community mental health services at rates far greater than their representation in the client population. In fiscal year 2002/2003, clients with the diagnosis of BPD cost our mental health acute and community system $9,486,585.

Clinical staff teams completed two weeks of intensive training in DBT by August 2003, and began developing DBT programs at their clinic sites. DBT consultation has continued to support DBT team development. In a recent CBHS study comparing service costs of 17 clients pre- and post- enrollment in DBT, there was a 34% reduction in overall costs and a 90% reduction in crisis and inpatient hours. Congratulations to everyone involved in the success of implementing this evidence-based practice in CBHS.

Executive Director
Ms. Brooke: We'll be holding the 10th Police Crisis Intervention Training from June 21st to the 24th. You are all invited to the graduation on the 24th at 4 p.m.

On Wednesday, June 23rd, Sgt. Mike Sullivan and I will be speaking to the Police Commission. All MHB members are invited to attend that meeting and speak during public comment time.

CONSENT CALENDAR

RESOLUTION (MHB-2004-21): Be it resolved that the minutes of the Mental Health Board meeting of May 12, 2004 be approved as submitted with an addition from Dorothy Shaffer. (Passed unanimously.)

RESOLUTION (MHB-2004-22): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of June 9, 2004, to the following members: Joel Luebkeman, chance martin, Toye Moses, Ted Stinson, Sandy Yuen, Dennis Yun (Passed unanimously.)

4.0 MENTAL HEALTH BOARD COMMITTEES

RESOLUTION (MHB-2004-23): SAN FRANCISCO'S BUDGET CRISIS

Part I
WHEREAS, Mayor Gavin Newsom in his first months in office has faced the largest deficit in the history of San Francisco, and

WHEREAS, Mayor Newsom has protected services that provide crucial help to the most needy residents of our city, and

WHEREAS, within Community Behavioral Health Services, the Mayor has protected programs which provide substance abuse services, along with both community-based nonprofits and Civil Service programs which provide mental health services, now therefore

BE IT RESOLVED, that the Mental Health Board of San Francisco commends Mayor Newsom for his personal, thoughtful, and strategic attention to the budgets of the City departments, on a program by program and line by line basis, a level of attention which is very uncommon for the mayor of a major American city, and

BE IT FURTHER RESOLVED, that the Mental Health Board of San Francisco thanks Mayor Newsom for his courage in taking a stand to continue funding as many services as possible for the City's residents most in need, and for protecting the City's long-term investment in residential care facilities and other irreplaceable programs.

Part II
WHEREAS, the cuts slated for Community Behavioral Health Services beyond the programs protected by the Mayor are still serious and cause for deep concern, and

WHEREAS, the current fiscal crisis threatens to continue beyond fiscal year 04/05, on into the next two to three years, and

WHEREAS, public health services could face devastating cuts as a result; and

WHEREAS, with regard to mental health services, the Bronzan-McCorquodale Act of 1991 (Section 5600 and following in the State Welfare and Institutions Code) outlines a complete system of care as the most effective and cost-efficient way to provide services and mandates that Counties to the best of their ability provide a comprehensive system of services, and

WHEREAS, in San Francisco, Community Behavioral Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, which meets the Bronzan-McCorquodale guidelines, and whereas, cuts will fragment that system and damage its cost effectiveness strategies, and

WHEREAS, a severe cut would mean that many clients of the mental health system who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, inpatient units at San Francisco General Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save, and

WHEREAS, the Mental Health Board further believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to respond to this crisis during the next years with a comprehensive revenue strategy, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the art services the city has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the sustainability of the community-based nonprofit organizations which deliver such a large percentage of its public health services, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured working citizens, and

BE IT FURTHER RESOLVED, in summary, that San Francisco be a role model and deliver a message to our nation about the importance of protecting our infrastructure and protecting all of our residents, even, or especially, during a time of international crisis and danger, and that we not end up losing the very things we are seeking to defend.
(Passed unanimously.)

RESOLUTION (MHB-2004-24): RESPONDING TO THE CRYSTAL METHAMPHETAMINE CRISIS IN SAN FRANCISCO

The Mental Health Board of San Francisco wishes to commend David Ibarguen for his courage in bringing the issue of crystal methamphetamine to the Board and emphasizing the magnitude of the crisis that currently exists with the abuse of this drug in San Francisco.

In Mr. Ibarguen's words, "Crystal meth has no conscience whatsoever. It steals, it robs, it takes everything."

The Mental Health Board wishes to commend Supervisor Bevan Dufty for asking the Board to co-sponsor a public hearing with him on May 12, 2004, on the issue of crystal methamphetamine and the damage it is currently doing to individual residents of San Francisco, their loved ones, and the community at large.

In response to this hearing, the Mental Health Board now resolves to recommend the following to the City and County of San Francisco:

1. That Community Behavioral Health Services (CBHS) provide and promote groups for partners, spouses, family, and friends, to give them the support they need and the strategies they need to cope with their loved ones and to intervene with them.

2. That CBHS continue to provide trainings as needed on assessing and treating crystal methamphetamine abuse and addiction and that these trainings be provided for all relevant staff, but especially for mental health clinicians and primary care clinicians within the Department of Public Health, and offer this training to the Wellness Centers and any other staff in the San Francisco Unified School District.

3. That the City do an assessment of the level of use of crystal methamphetamine in San Francisco, looking at what motivates its use, what particular groups are most impacted by it, and what would be the most effective prevention and intervention strategies.

4. That the City design specific treatment responses to meet the needs of different groups within San Francisco, including the gay community, the African American community, and youth.

5. That the City design and promote a public education campaign to make people aware of the dangers of crystal methamphetamine, to let people know where to call or go for help, and to help prevent people, especially young people, from ever getting started on this drug.

Finally, the Mental Health Board would like to pass this resolution in memory of Neil Lewis and the many, many other San Franciscans whose lives have been destroyed by crystal methamphetamine. (Passed unanimously.)

Ms. Shaffer: I represented the Mental Health Board at "Partnering for Safe Schools," which was put on by the school district and which was also called the "2004 Parent Convention." District Attorney Kamala Harris was the keynote speaker. I would encourage inviting her to come speak to the MHB because a lot what she wants to do are things the MHB supports.

Dr. Turner: I did a program review at Edgewood Children and Family Center, at their program at 1 Rhode Island Street. I met with all the staff and the director. Their referrals come from the schools, foster care mental health, and CBHS clinicians and case managers. They have a kinship program to support caregivers for the children.

The environment at the Center is very relaxed. It's more like a family environment than a clinic. When they get a referral, they call the clients directly within a few days. Some places wait for the clients to call and clients feel shy about it and procrastinate.

Data collection on outcomes could be better, but when they told me how much paper work they have to do, it made sense. They do their own internal research. But it wasn't clear how feedback from the research got into the system to make changes.

When I asked staff about their challenges, in addition to funding challenges, they said they spend 40-60% of their time on paperwork, documenting services. That's disturbing to me. It means we only have half a person for every person we employ. I feel very revved up about this. There has to be a way to get accountability without people spending that much time on paperwork.

I was impressed with the staff, and their openness and willingness to invite me back if I wanted.

5.0 NEW BUSINESS
No new business.

6.0 PUBLIC COMMENTS
Mr. Kalman: I'm concerned about the Mayor's budget report. There are key things I can't find in here. I don't know what's going on with integration. There is a proposed closure of four day care centers which is related to money. Also I don't know if it's legal with the state and federal codes to do the integration. And this is also connected to Laguna Honda.

7.0 ADJOURNMENT
There being no further business, the meeting was adjourned at 8:34 p.m.

Mental Health Board

July 14, 2004

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, July 14, 2004

1380 Howard, Room 537

6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

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1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)

For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of June 9, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 14, 2004, to the following members: Sandy Yuen, Bob Douglas

2.0 PRESENTATION: Public Schools and Mental Health Services (45 minutes)

Commissioner Heather A. Hiles, Board Of Education

2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

3.0 DIRECTORS REPORTS (25 minutes)

For discussion.

3.1 Report from the Director of Community Mental Health Services

A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board

A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee

The Chair will report discussions and actions of Executive Committee.

Discussion of budget policy and strategy.

4.2 PROPOSED ACTION: Resolved that the Mental Health Board will cancel its meeting for August 11, 2004.

5.0 NEW BUSINESS (5 minutes)

Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)

This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

7.0 ADJOURNMENT

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San Francisco, CA 94102-4689
Telephone: (415)554-7724
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Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

UNADOPTED MINUTES
Mental Health Board
Wednesday, July 14, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Augusta Del Zotto, Ph.D. (Acting Chair); Bridgett Brown; LaVaughn Kellum-King, Carol Knight, M.A.; chance martin; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.; Idell Wilson; Dennis Yun, M.S.W.

BOARD MEMBERS ON LEAVE: Bob Douglas, J.D.; Supervisor Bevan Dufty; Joel Luebkeman; Ted Stinson (Chair); Sandy Yuen; Kate Walker.

BOARD MEMBERS ABSENT: none

PRESENTERS:
Commissioner Heather Hiles, Board of Education

OTHERS PRESENT: Robert Cabaj (Director, Community Behavioral Health Services); Edwin Batongbacal (Associate Director, Community Behavioral Health Services); Sai-Ling Chan-Sew (Director, Children's Services, CBHS); Roban San Miguel (Family Mosaic Project); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:47 p.m. by Dr. Del Zotto, Acting Chair.

The Consent Calendar was moved to later in the meeting.

2.0 HEATHER HILES

Dr. Del Zotto: Mayor Gavin Newsom appointed Heather Hiles to the San Francisco Board of Education on January 12, 2004. Since assuming the seat, Heather has become a vocal advocate for public school children, families, teachers, and staff.

Heather's passion for excellence in public education comes from her own experience as a student in public schools in Los Angeles and Santa Barbara. Raised by a determined single mother, Heather was encouraged to challenge herself and achieve in school. She was the only person of color in her high school to take college prep classes and sit for

the SAT—in a school that was over 50% African-American and Latino. Heather went on to the University of California Berkeley (UCB) and then to get an MBA with an emphasis in Finance and Strategic Planning from Yale University School of Management.

Ms. Hiles: Thank you for having me here today. I wanted to introduce myself and let you know what's happening at the School Board, and I'd like to hear what's happening with you at the Mental Health Board, and talk with you about the intersections of our work.

I don't have much of a mental health background, but I have worked with underserved populations for years.

I have been up here in the Bay Area about 17 years. While at UCB, I ran a program called "Break the Cycle." In this program, UC students tutor K - 3rd graders not doing well in school. Mostly the parents were not engaged with their children. So we worked with the families, and this was a very successful program.

I worked at Castlemont High School with a job program. There were 60 students, all needing income from after-school jobs, because their basic needs were not being met by their families. I spent the majority of my time counseling these young people who were trying to survive. I know first hand from them and from some of my family members what it's like to be trying to survive.

I got an MBA, and then worked in the financial sector for some years. Then I was invited to be first Executive Director for San Francisco Works, working with people on welfare and the incarcerated population. It struck me how many of our adults who had graduated from high school could not read and write adequately. We worked intensively with them to get them marketable and to get them jobs in health care and legal services. We worked hard to get them living wage jobs. But the biggest issue they were facing was the depression and the challenge of living from paycheck to paycheck.

It's so hard to survive in this city, for young parents trying to maintain families, for people with issues.

Out of SF Works, I created a nonprofit called SF Earns. We matched 2:1 what our clients were saving for a house, and for starting a business. There are 450 accounts open now.

Next I started my own business working with foundations. I had raised money from 100 foundations, when I met Mayor Newsom through his wife. He asked me to be his communications director on his campaign. I wrote policy papers, including one on the schools, which was the most complicated, difficult of the papers to write. There are not many best practices in urban school districts for turning things around for African American students.

In San Francisco, we have the highest private school population—30% of our students. At one point we had 90,000 children in public schools, and now that's down to 55,000. Many working and middle class families have left the city.

Over 5,000 kids are absent at least once a week. We are not engaging these children and young people.

I was just in the Mayor's office before this meeting in a planning session. What if we can attract private school students back to the public schools because we improve quality? Trying to do this is like pushing the boulder uphill. But I think we can do it. And we have a mayor who is rolling up his sleeves. This planning group meets once a week. The Mayor has a liaison to the schools. We also have the Superintendent who has been doing a phenomenal job.

We are working on making our low performing schools become high performing schools.

In terms of the work we're doing, my first resolution on the School Board was to support the Dream Schools Initiative, designed to turn our lowest performing schools into world-class academies. We're looking at increasing the time for these schools, so students would attend every other Saturday. There would be a big shift in the curriculum.

One resolution I passed had to do with the issue of sexual assault. This came to my attention during a Youth Commission meeting. Teachers were saying that sexual assault cases were happening in the schools, but they were not prepared to identify sexual assault cases and what to do. The reporting rate is very low. I met with the head of the child sexual abuse center. They offer free training to the teachers, but only a few schools have taken advantage of this. My resolution is a plan for all of our teachers and schools to go through the training. And it's free training; it's not costing the City anything.

Jeremy Shafer: How do you plan to change the school district? What do you plan on changing?

Ms. Hiles: There are a bunch of things. I want to focus on the Dream Schools for now. We have 17 schools in the District which are low performing that we need to turn around. We need to get the City and business engaged.

We have to make sure we have very motivated principals at these schools, that's the number one factor. We need to create a situation where good teachers are rewarded, and bad teachers are not. Unfortunately we have a seniority system now and in the lay offs we lost some very talented teachers. We need to find role models and resources for our children. There are some best practices which we need to spread throughout the District.

Mr. Shaffer: There is so much more money for jails than for schools.

Ms. Hiles: If you go to the jails and prisons, so many of them are new and guards are making more money than teachers.

We are investing in alternatives to incarceration to prove that if you invest in kids, you can prevent huge costs in incarceration down the road.

We are investing in alternatives to incarceration to prove that if you invest in kids, you can prevent huge costs in incarceration down the road.

I was working on this with the Mayor earlier today. It's called Project Connect. We've gone into four housing projects and asked families what they need. We need to hear that first.

Ms. San Miguel: How are the schools responding to gun violence. Students are traumatized and teachers are traumatized. How can we coordinate better?

Also, what about the issue of asthma and problems with School District buildings?

Ms. Hiles: We need collaboration. We are at a crazy point, and I hope it has peaked. It has been unimaginable how much violence has taken place in our neighborhoods, especially Visitacion Valley, Bay View, and Western Addition.

In Visitacion Valley, two weeks ago, when students went to school in the morning there was a 20-year-old male dead on the doorstep of the school. The School District is becoming more responsive when there is a crisis, but the fact is, we've cut back on counselors.

At Visitacion Valley Middle School, a fire cracker went off for Chinese New Year. All the kids hit the ground, because they thought it was a gunshot.

There is a hot line 24 hours a day, students can call if they if feel harassed. That has made the school environment feel safer. But we obviously need to do much more than that.

It's a wonderful practice to have mental health programs on the school sites. And the same with the Wellness Centers. Students tell me how much they matter. They don't know what they would have done without that support.

Mayor Newsom is the one who authored the resolution to get the Wellness Centers into the high schools.

We met with the Asthma Task Force, which is working hard to make a long-term plan. I've been to schools that have rats, mice, and peeling paint, and there is no reason in this city that that should happen. I want to take the media on tours of the schools with the Mayor.

Ms. Chan-Sew: Thank you for your support for Wellness Centers. However, there is very little money for mental health and substance abuse workers. Often there is only one such staff person for a school of 1,000 students.

Also I'm concerned about kids in regular education and special education when they move from kindergarten to elementary school and then on to middle and high school. Some ideas include creating summer camps for students. We'd like to generate support systems for transitions.

Ms. Hiles: The transition from preschool to kindergarten is a very big one as well. A report has been designed for kindergarten teachers to have so they can know about the students they get at the beginning of the year.

The transition from 3rd to 4th grade is a key time. If kids aren't reading well at that point they are more likely to drop out later on.

I visited the Edgewood Center's program, and saw an 8th-grade graduation, and saw the kinship program. Many of the children have been through serious changes in their family. A lot of them don't live with parents, and they talk about their stresses and fears about going into high school. There are a lot of things they are worrying about.

I'm very open to learning from you what would help. I will advocate with Proposition H money, for more mental health services. Wellness Centers should be at all middle schools as well as the high schools.

Ms. Chan-Sew: We have students with mental health issues, but they can excel. We need to review the curriculum for special education.

Ms. Hiles: Special education is also a huge area of importance. Special education is disproportionately composed of African American and Latino children. We need programs to mainstream kids and provide tutors to be with them in general education. The kids in inclusion are almost all Asian and white.

There was a teacher who was closing the door on her African American kids because she felt they were too disruptive. That's unacceptable. In the special education class I visited, two students were sleeping with a teacher and para-professional in the classroom. I went to the principal about that.

We have 7,000 kids in special education. It's a very big department with so many needs. I think they're doing a fair job.

Psychologists give the tests and do the IEPs, but they are not connected to implementation. We can do better in this area.

Ms. Kellum-King: I worked in the schools in the past and saw parents come in and they were totally disillusioned. We need programs so the schools are user friendly to the parents. We need trainings for parents to give them a sense of belonging. And we need to include grandparents as well.

Ms. Hiles: My first month on the Board, I went to the Davis School. I asked the staff to set up a focus group, and asked them what they wanted. One of first things they said was parent support.

I want to make sure parent involvement happens at the Dream Schools.

Ms. Knight: I'm a native San Franciscan and went to school here. I went to George Washington High School. The same terrible conditions are still there. I was there for a test recently and I was crying. I could hardly even take the test. I'm angry about how

tax money is used, or not used. The bathrooms are terrible. It's been a very long time that the conditions have been so bad.

Ms. Hiles: Yes, that's unacceptable. If you just took out the loopholes in Proposition 13, there would be so much more money for our schools.

Ms. Knight: When I went to school, we were not allowed to get in little groups. We had to all play together. Until you teach children to get along together, we have to fear for safety.

Ms. Hiles: I believe we'll integrate our schools better if we bring up the quality of all our schools. In the Bay View most of the students are African American. There are a large number of Asians living there, too, but they send their children to other schools.

The consent decree spent $40 million on integrating the schools, and the schools are still not integrated. So what we've been doing has not been working.

Ms. Wilson: When will they grade children for what they do? There are kids getting into fights. My son was at school and his sister went to pick him up. Children are always picking on him. Somewhere it's not clicking that there are consequences for hitting or abusing a another child. My daughter walked up on 5-6 children beating up my son. He was on the ground holding his head. I've been to that school and talked to the principal. There needs to be consequences.

Ms. Hiles: Let me know outside this meeting the name of the school and the principal and I will follow up on it.

Dr. Del Zotto: Some officials in local government have the view that if the children go to good schools, and they get into trouble, they are under stress and need mental health services, but in other schools, if kids get in trouble, they're labeled as violent kids.

Member of the public: It's important that teachers learn to manage behavior.

Ms. Shaffer: I've been going to a lot of school meetings focusing on safe schools. Certain schools do not want in-kind services. They consider it like a stigma.

It would be great to facilitate training and support services free of cost for our schools. But we hit a brick wall. I'm a school nurse in Oakland, and I do all kinds of programs. I get $250,000 of donated services every year.

Ms. Hiles: One of the things we need is a cultural shift. It is not a sign of weakness to get help. We need legislation to open school playgrounds and upgrade them for weekend use. Would love to work with you in putting ideas together.

Ms. Shaffer: The Children's System of Care is willing to come to schools, and do presentations. But we are not always able to get into the schools.

Ms. Hiles: Give me the information and I'll follow up on it. There are great programs like Hilltop.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services (CBHS)

Dr. Cabaj: The budget is still open. July 27th, the Board of Supervisors has to give it back to the Mayor. Most of what we thought we were going to lose has been put back.

We thought we were going to have to close the Mission and Sunset clinics. Through the work of clients, neighbors, Supervisors, the Mayor, and the unions they have been saved. The Mayor himself made the decision to put them back in the budget. This was about a $5 million change. The Supervisors also saved Team II and Southeast Geriatric clinics.

Behavioral health will still be taking some cuts. We may lose some administrative staff due to cut backs and in some positions we'll have different staff because of bumping by other Civil Service staff. For example, my assistant, Behki Ona, will have to leave after 17 years here.

Even though the clinics are fairly intact, there will be some fallout from the administrative issues. We may have some trouble keeping up with billing and compliance, and that may have some revenue impact.

Contractors are facing a cap on administrative costs, which will end up being a cut in their contracts. And it will be a total of $1.5 million. Primary Care is taking quite a few hits, including all the directors of the clinics.

Dr. Turner: Talk about prevention efforts.

Dr. Cabaj: The Mayor has made this a high priority. And it sounds like from our presentation earlier he has some ideas. Sai-Ling Chan-Sew has prevention programs in the Children, Youth and Families Section of CBHS. In the Department of Public Helath (DPH) as a whole, Ginger Smyly is in charge of prevention programs.

We're trying to prevent post-traumatic stress disorder (PTSD). There is evidence that if you can jump in early and help people work through a trauma right way, and help them get some control back in their life, that helps prevent PTSD.

Ms. Brooke: Women do better in groups with women, especially at the beginning of their treatment and recovery. Is that being considered?

Dr. Cabaj: The consultants we've hired to work on integration with us will be looking at all the special needs people have. On September 2nd and 3rd, we'll be pulling together some groups to provide the consultants with information. And then they'll be coming back periodically. Hopefully we'll be working with a very broad constituency.

Dr. Moses: I want to commend you on the changes you've made since Jo Ruffin left. I'm happy to see the updated organizational chart. I'm happy to see the diversity you've created.

I'm wondering if you could give us an update on the future integration of the Treatment on Demand Council (TOD), the Citywide Alcoholism Advisory Board (CAAB), and the Drug Abuse Advisory Board (DAAB), with the Mental Health Board (MHB).

Jail Psychiatric Services is being cut. It's such a good program and they do wonderful work. To see that program fading out is terrible.

Dr. Cabaj: The goal is still to create one single advisory board. Since the MHB has the state rules, this is the Board that will be the main structure. The CAAB and DAAB have somewhat ceased functioning, and they are more integrated into the TOD. I've been talking with Helynna about doing more integration. We hope to come up with one advisory board, respecting the legislative framework.

With regard to Jail Psychiatric Services, one of the policies set by DPH is that when a program loses a grant, then the City wouldn't necessarily cover that loss. But we just learned that the budget allowed most of the jail mental health services to stay in place, which will allow the Behavioral Health Court to continue.

Dr. Moses: Jail Psych is so cost effective it makes no sense to phase it out.

Dr. Cabaj: I agree.

Mr. Kalman: How much money was left from last year that was not used?

Dr. Cabaj: The City budget doesn't work that way. There isn't money left over. CBHS, doesn't have a direct budget, it all goes through DPH. All of the monies are used up each year. There is no reserve fund for CBHS under City Charter. Every year it gets very lean at the end of the year. We have to zero out at the end of the year.

The Director's written report was distributed:

1. Budget News. As part of the 04-05 budget restorations, Team II and Southeast Mission Geriatric mental health clinics will now be able to stay at their current locations. The Budget Committee of the Board of Supervisors restored $8.3 million in General Fund to the Department of Public Health, allowing the saving of programs that the Health Commission designated as highest priority to restore if money were available. The Committee restored $1.7 million in Primary Care services, $1.7 million to backfill Ryan White CARE Act cuts, and $925,000 for AIDS emotional and practical support programs. Other restorations included the SFGH Dialysis Clinic, interpreter services at SFGH, social work managers, Mt. St. Joseph's Epiphany Center, DEAP program, Primary Care administration, and elimination of the pharmacy co-pay. Jail Heath Services expenditures will be reduced by $3.0 million as a replacement for the Mayor's proposal to outsource the services for an estimated savings of $4.5 million. A Blue Ribbon Committee will make recommendations for future years budgets for Jail Health Services.

The Budget Committee recommendations will be forwarded to the full Board for action. As proposed, the Department shall sustain a $20.2 million reduction to its General Fund, but will avoid potentially serious service cuts.

2. CBHS Crisis Staff Acknowledged. The CBHS Gun Violence Response and Recovery Team is the recipient of this month's Department of Public Health Team Award. The Team has been coordinating the CBHS assistance to youth and families impacted by the recent escalation of gun violence in the southeast part of the City, including Bayview Hunter's Point, Visitacion Valley, Potrero Hill and Western Addition. This behavioral health team provided counseling, help in obtaining victim assistance services, coordination of funeral and support services, and crisis counseling for family members in the emergency room at San Francisco General Hospital. It provided debriefing services in schools for students traumatized by deaths of fellow students and shootings around their schools or neighborhoods. The Team also organized a series of evening community forums on violence and its impact on youth and families, and is now planning to conduct regular de-briefing meetings for those impacted by the violence, including for City and other service staff responding to assist.

The Gun Violence Response and Recovery Team is comprised of staff from the Critical Incident Response Team, Comprehensive Child Crisis Services, Children's System of Care Family Involvement Team, Family Mosaic Project, Cultural Competency and Consumer Relations Section, and the DPH Prevention Unit. The Team has been working closely with other violence prevention/intervention efforts such as the DPH Violence Prevention Project, Gang Free Initiative, Visitacion Valley Violence Prevention Project, CLEAR Project, as well as with public partners such as the San Francisco Police Department, SF Unified School District, and the faith-based community.

3. 10-Year Homeless Plan. On June 30, the City unveiled the "The San Francisco Plan To Abolish Chronic Homelessness." The plan calls for the development of 3,000 supportive housing beds based on the "Housing First" principle that places chronically homeless people directly off the street into housing and then actively engaging residents to promote stability and improved health and well-being. Mental health and substance abuse treatment services figure prominently among the health needs to be provided to homeless individuals. The ten-year plan is a long-range blueprint for improving the city's homeless services. The federal government has made the creation of these Ten-Year plans integral to securing additional resources for homeless initiatives.

4. 1st CBHS Integration Consultant Visit. ZiaLogic's first behavioral health integration consultation visit to San Francisco will take place on September 2 and 3, 2004. On these dates, ZiaLogic will sit down with the CBHS core executive leadership team to develop the broad contours and stages of a two-year planning and implementation process to integrate mental health and substance abuse services in San Francisco. This would include setting the overarching vision for change, and the stages of and priorities for implementation—including in the areas of welcoming, screening, data capture, and assessment.

During their September visit, ZiaLogic will also meet with broader groups of stakeholders in the San Francisco mental health and substance abuse systems of care to conduct briefings on:

--the Comprehensive, Continuous, Integrated System of Care (CCISC) model,
--what will be the shape of the San Francisco planning process, including stakeholder involvement in a planning group,
--the drafting of a charter document on integration to which all can sign on, and
--a program evaluation toolkit.

The emerging vision for an integrated behavioral health system of care in San Francisco will include the following principles:

--Any door is the right door: "Welcome, you're in the right place" will be the warm message all clients will receive at all entry points of the integrated system.
--Dual diagnosis is the expectation, not the exception.
--All programs will be "dual-diagnosis capable."
--Both disorders will be treated and addressed.
--Integrated treatment will be the standard of practice.
--Not all dually-diagnosed clients are the same, each type of client will be provided with different appropriate approaches to care.
--Best practices will be employed, such as harm reduction, motivational interviewing, and the use of the stages-of-change model.
--Hope will be instilled, and the inner strengths and potentials of all clients will be recognized at all times.
--Peer recovery model will be promoted throughout the system.
--Clients will be empowered and respected.

5. Proposition 63. The Mental Health Services Act, Proposition 63, if passed by voters in the November ballot, will fundamentally change mental health care in California. Proposition 63 will add about $1 Billion per year for mental health care in the state. The measure will expand provision of care to people currently disabled by mental illness, people in need of prevention services, and their families and caregivers. The services will be based on effective models of comprehensive care. These expanded programs will be paid for by a surcharge of 1 percent on income above $1 million per year. A new oversight and accountability commission in the state will supervise the expansion of services.

6. A client's progress. I would like to share the following story, sent in by Jim Tate, Director of the AB 2034 Homeless Mentally-Ill Outreach Team, on the inspiring progress one of their clients is making (shared with the client's permission):

We recently drove Tom (not the real name), one of the AB 2034 Transition-Age Youth clients, to his four-month work program in Yosemite —a program that accepted a small number of troubled young men and women to live and work in a summer resort.

Tom was enrolled with our program 18 months ago. He was referred to us by Jail Psychiatric Services and had already served a 6-month sentence. He began engaging

in criminal behaviors and amphetamine use at fourteen years old. He had stolen automobiles, plotted murders, and more recently, turned his anger toward himself with an incident of deep self-cutting. He also reported hearing command voices and in fact had experienced a severe break with reality with continued residual effects. He, like many of our clients, experienced physical, sexual and psychological abuse as a child.

Tom was motivated and resilient however. He worked closely with our team. He enrolled in Dialectical Behavior Therapy and was consistent with the treatment. He developed a relationship with our employment counselor, and followed case management direction to secure and retain housing. He accepted the fact that continued drug use would catapult him backward to his previous life. He used his newly acquired skills to manage the voices in his head. He refrained from self-harm and used the after hours call line effectively to learn how to manage stresses without the use of drugs, cutting or rage. Our AB 2034 team continues to support Tom, and the report is that he is doing very well at Yosemite.

I wish to convey appreciation to all of the programs in CBHS, like AB 2034, who make a difference in the lives of so many individuals with mental illness and substance abuse disorders. Thank you for all of your dedicated work.

3.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke announced the upcoming MHB Reception on July 15th.

4.0 MENTAL HEALTH BOARD COMMITTEES
Dr. Del Zotto: Our Chair, Ted Stinson, just started a new job and will be moving to Palo Alto. Therefore he will be leaving the Board in the near future.

This means we will be voting on a new Chair in September. The Nominating committee will consist of Ted, Bridgett, and Toye.

RESOLUTION (MHB-2004-25)
Be it resolved that the Mental Health Board cancel its August Board meeting. (Passed unanimously.)

The next meeting of the Mental Health Board will therefore be on September 8, 2004.

CONSENT CALENDAR

RESOLUTION (MHB-2004-26): Be it resolved that the minutes of the Mental Health Board meeting of June 9, 2004 be approved as submitted. (Passed unanimously.)

RESOLUTION (MHB-2004-27): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 14, 2004, to the following members: Joel Luebkeman, Bob Douglas, Ted Stinson, Sandy Yuen. (Passed unanimously.)

5.0 NEW BUSINESS

Ms. Shaffer: It would be interesting to follow up with Heather Hiles and school programs later on.

6.0 PUBLIC COMMENTS

Ms. Hewson: How come there is no guidance for psychiatrists on administering medications? This is very important. They have kept my son in the hospital for 5 years now. It's ridiculous. He's a very healthy person. They change the medications all the time. Doctors keep moving on. Psychiatrists put him on a whole lot of medications and they don't look at his previous record to see what works for him. They don't look at the obvious thing.

mr. martin: I think the best encapsulation of mental health care today is it's on a par as a science with where medicine was in the 16th century. Unfortunately the pharmaceutical industry is the most profitable industry on the planet. The mark up on Prosac is 179,000%. A lot of the safety regulations have been eroded.

Ms. Hewson: Psychiatrists are not trained on medications. There's lots of information , but psychiatrists don't read it.

mr. martin: The health beat reporter for the Boston Globe wrote a book called *Mad in America*, about the alliance between the pharmaceutical industry and mental health services.

Ms. Shaffer: This is a topic we could have on a future agenda, including medication for children. That would fit in with some of our priorities as well.

mr. martin: Dr. Warren Mosher, a dissident psychiatrist, who recently passed away, ran the Sotera Project and treated schizophrenia without drugs.

7.0 ADJOURNMENT

There being no further business, the meeting was adjourned at 8:25 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103-2614
(415) 255-3474 fax: 255-3760
TTD: 255-3449
mhb@igc.org
www.sfgov.org/mental_health

The Mental Health Board meeting scheduled for August 11, 2004, has been CANCELED

The next meeting of the Board will be Wednesday,
September 8, 2004,
in Room 537 at 1380 Howard Street.

An agenda for that meeting will be sent out at the beginning of September.

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, September 8, 2004
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of July 14, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of September 8, 2004, to the following members:

2.0 PRESENTATION: SCHOOL RESOURCE OFFICERS (45 minutes)
For discussion.

Lt. Colleen Fatooh will present about the role of School Resource Officers in San Francisco Schools and observations about student needs.

2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

3.0 DIRECTORS REPORTS (25 minutes)
For discussion.

3.1 Report from the Director of Community Behavioral Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.
Discussion of budget policy and strategy.

4.2 PROPOSED ACTION: Election of a new Chair for the Mental Health Board.

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

7.0 ADJOURNMENT

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the

removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from Ms. Hall, or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: **www.sfgov.org/sunshine.htm**

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: **www.sfgov.org/mental_health**. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES
Mental Health Board
Wednesday, September 8, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Bob Douglas, J.D.; LaVaughn Kellum-King; Carol Knight, M.A.; Joel Luebkeman; chance martin; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.; Kate Walker; Idell Wilson; Sandy Yuen; Dennis Yun, M.S.W.

BOARD MEMBERS ON LEAVE: Augusta Del Zotto, Ph.D.; Supervisor Bevan Dufty.

BOARD MEMBERS ABSENT: none

PRESENTERS:
School Resource Officer program, San Francisco Police Department
Lt. Colleen Fatooh
Officer Brenda Rodgers
Officer Debbie Adams
Officer Matthew Balzarini

OTHERS PRESENT: Edwin Batongbacal (Associate Director, Community Behavioral Health Services); Sandra Santana-Mora (Edgewood Center); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:37 p.m. by Carol Knight, Acting Chair.

CONSENT CALENDAR

RESOLUTION (MHB-2004-28): Be it resolved that the minutes of the Mental Health Board meeting of July 14, 2004 be approved as submitted. (Passed unanimously.)

RESOLUTION (MHB-2004-29): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of September 8, 2004, to the following members: Augusta Del Zotto. (Passed unanimously.)

2.0 SCHOOL RESOURCE OFFICERS

Lt. Colleen Fatooh is the officer in charge of School Resources Officers and Youth Services. She has been in the San Francisco Police Department since July 1, 1985. She was in the field for ten years as a patrol officer. She was then a Sergeant Inspector in the Juvenile Division, specializing in child abuse. She was put in charge of the School Resource Officers four years ago. She made Lieutenant in June 2004.

Lt. Fatooh: The School Resource Officers (SRO) are dedicated to making sure that our schools are safe. We are able to provide valuable resources to school staff and youth. We hope to prevent and solve problems.

We are currently staffed by 27 full-time resource officers. We have officers in every high school and a majority of middle schools. We're moving up to 30 officers in the next couple of weeks.

Lt. Fatooh, then made a PowerPoint presentation as follows:

MISSION STATEMENT

- Dedicated to working with SFUSD to ensure a safe learning environment.
- To provide valuable resources to school staff, teachers and youth.
- To prevent and solve problems within the school community.
- Foster positive relationships between youth and police officers.

WHERE WE ARE TODAY

- Currently, the SRO Program is staffed by 27 full-time SROs assigned to most high schools and some middle schools.
- SROs are supported by 11 district school cars.
- In addition to regular school day duties, SROs supervise and ensure the safety of students at a majority of school events, including dances and athletic games.
- SROs also participate in community events.
- SROs work extensively in youth summer programs, including the Clean Team, Recreation and Park sites, Beacon Centers, SCORES and supervise summer school.

SCHOOL RESOURCE OFFICERS POSITIVELY IMPACT OUR SCHOOLS

- Provide home visits
- Reduce truancy
- Provide classroom safety education presentations.
- Provide case management services for students.
- Participate in Student Assistance Program meetings.
- Attend Student Success Team meetings.
- Coordinate and attend field trips.
- Refer students and families to community resources.
- Conduct professional development presentations for faculty and staff.
- Counsel students and facilitate conflict mediation.
- Provide a safe school environment.
- Provide substance abuse and violence prevention education.
- Facilitate support groups.

• Support counseling staff.

SRO LAW-RELATED EDUCATION
• School Safety
• Stranger Danger
• 101 G.R.E.A.T. (Gang Resistance Education & Training)
• Project Alert
• Street Law

SRO GOALS
• To maintain safe, secure, and attractive school environments.
• To enhance the educational process by improving relationships among the students, parents, staff, community and police.
• To facilitate positive collaboration and communication between police and students.
• To serve as a mentor by modeling self-esteem.
• To be a critical thinker, problem solver and effective communicator.
• To enhance the learning environment by teaching law-related education (LRE) curriculum.

HISTORY OF OUR SRO PROGRAM
• Pre-1999: School cars or "29 cars." Reactive vs. supportive.
• The Mayor's Office of Criminal Justice initially funded part-time middle school officer program, which placed two officers, five hours per week, at 17 middle schools through an annual block grant.
• 1997-98: Juvenile Crime statistics (derived from police reports, juvenile arrest records and school district data):
295 batteries
165 weapons possessions
113 alcohol/drug-related incidents.
• Those statistics prompted an expanded collaboration between police department and school district.
• In 1999, SFPD secured funding from the US Department of Justice's Office of Community-Oriented Policing Services (COPS) to place full-time SROs at most high schools and some middle schools under its COPS in Schools program.
• Also in 1999, SFUSD secured a grant to support the Safe School Healthy Student Initiative program which created a team of nurse, peer counselor, administrative staff & SRO.
• On June 1, 1999, SFPD and SFUSD entered into a memorandum of understanding pertaining to the federal COPS in Schools grant, "in order to reduce violence within primary and secondary schools in the City of San Francisco."
• Revised: March 1, 2001.
• Both the initial and addendum MOUs were reviewed and approved by the Chief of Police, Superintendent of Schools and the City Attorney.

STATE GRANTS
• The California Office of Criminal Justice Planning funded two grants:
1. High Flyers 9-1-00 to 8-30-03.
2. Drug Suppression in the Schools 1998 to present, which focuses on Balboa High School, Visitacion Valley Middle School, Luther Burbank Middle School and some

elementary schools & employs SROs using intervention/prevention methods. It supports the SCORES, Kidstock and peer resource programs and wilderness activities.

FEDERAL GRANTS
• The US Office of Juvenile Justice Delinquency & Prevention funded On Track from 7-1-00 to present, which provides a truancy prevention program at Visitacion Valley Middle School where an SRO and case manager partner to work with at-risk youth who are chronically truant.
• OJJDP selected our successful program to be included at an upcoming presentation to the US Congress.

SAFE SCHOOLS TASK FORCE
Task Force is a collaboration of SFUSD, SFPD, City Attorney, DA, MUNI, youth advocates, CBOs and community members.

SAFE SCHOOLS TASK FORCE RECOMMENDATION
• Review & update the MOU so to clarify the roles of SROs.
• Involve SROs in school sites beyond their functions as officers to establish trusting and effective relationships with students.
• Provide cross trainings for SFPD and SFUSD staff to address issues such as the respective roles of SROs and staff administration and working as a team at school.
• Recruit SROs that are a good match for school environment.
• SFUSD should participate in bi-weekly SRO meetings to be informed about the incidents that have occurred on school sites.
• SROs should be a part of critical incident response planning.

CIVIL GRAND JURY
During 2002-03, the San Francisco Grand Jury conducted hearings regarding SFUSD's truancy rates. The Grand Jury produced a report that mandated a response from SFPD.

CIVIL GRAND JURY RECOMMENDATIONS
• Assign full-time SROs to all middle schools.
• Implement a truancy prevention program (i.e. "On Track") at every middle school.
• SRO to deliver the first written warning of truancy to the youth.

SFPD RESPONSE TO THE GRAND JURY
• We support the three recommendations.
• We will implement the first two recommendations upon receipt of additional funding for which we've applied.
• The protocol for the third recommendation, SRO to deliver 1st written truancy notice, is currently under discussion within the citywide Stay in School Coalition.

COMPONENTS OF THE YOUTH SERVICES UNIT
• SRO Program
• Wilderness Program
• Police Athletic League (PAL)
• GREAT

CHIEF'S DAY AT THE MOVIES
• Sponsored by the SRO Program and Loews Theatres.
• Held at the Metreon Imax.

RED RIBBON RALLY
• The SRO Program produced the annual rally where 300 middle school students from across the city come together to learn about drug, alcohol, and tobacco prevention.

Lt. Fatooh continued as follows: We do community events, like the recent backpack giveaway we did in Hunters Point. We take our horse unit and our talking car into the communities where our officers are serving.

Our officers serve in a mentoring role for students by modeling good self-esteem. They teach students to be critical thinkers.

We do law-related education regarding drugs, alcohol abuse, tobacco use, sexual harassment, drunk driving, and bullying. We go into elementary schools to teach about bullying, stranger danger, and child abduction. We talk with teachers about mandated reporting.

We facilitate conflict mediation, facilitate support groups, and support counseling staff. We have a wilderness program and take kids on outdoor activities.

Dr. Turner: In the youth survey we learned how many kids come to school with weapons. Counselors are saying that kids have to go through neighborhoods where they need to carry weapons for self protection.

Lt. Fatooh: That's what kids say. For a lot of kids in this city, that fear is a real concern. A lot of times when they are not at school, kids say it's because they are afraid. The number of weapons have gone up.

Officer Balzarini: I work at John O'Connell in the Mission. We're right in the middle of gang territory. A lot of students come to school because they are scared of the gang territory. Sometimes kids are cutting class, but they are at school because they feel safe there. I am out there when the kids are leaving school to make sure they are safe.

Officer Adams: I work at Burton High School in the Sunnydale and Visitacion Valley area. I have kids from all over: Oakland, the Richmond District, and the Fillmore. I've learned to watch whatever group of kids is having issues.

If kids from Sunnydale are having issues with kids from Hunters Point, then I keep an eye on them. You can suspend a kid, and they still will come back to school. If you stay on campus you can get arrested because you're suspended, but we understand that the school is their safe haven.

Officer Balzarini: A very small percentage of what we do in the schools is law-enforcement related, Most of the time we're counselors, father figures, or friends. If

someone knows a kid has brought a weapon to school, they'll tell us. They don't want weapons at school. That's often how we find out.

Dr. Turner: Is it true that the largest percentage of weapons brought to school are knives? Officer Balzarini: In Bayview Hunters Point, there are more guns. Latinos use knives and throwing stars. Lt. Fatooh: Overall there are more knives.

Officer Adams: Most often these are pocket knives. One young lady took a Swiss Army knife to school and was playing with the other tools, but didn't even realize that it had a knife. Still she had to be suspended.

Ms. Brooke: Do you actually collect the weapons from the kids and confiscate them?

Lt. Fatooh: For years, principals had a drawer of confiscated weapons. Now any weapon used in a crime is taken in for evidence.

Ms. Kellum-King: I want to praise the Police Department and say thank you for being here tonight. I know Officer Adams runs a program. And Officer James Bell has a great way with the children. Each one has a granddaughter of mine at their school. My second granddaughter is just starting middle school. The officer there is helping her with the transition. Thank you, all of you, for doing a good job!

Lt. Fatooh: We have 15 officers at high schools and 13 at middle schools. We've applied for new funding through the federal government for up to 35 officers for a three-year period. If not, we hope the Police Department and the City will continue to support this.

Eighteen of our positions will expire in June of 2005. We're hoping to have a new grant in place by then. We've got an 85% retention rate in our unit. We have some of the original officers we started with. We have great relationships with parents and communities. They sometimes request that an officer stay at the same school and not do a transfer.

Ms. Shaffer: One of the things Heather Hiles brought up when she was here is crimes occurring on campuses and the problem of teachers not reporting them and not knowing what to do about them. Do SRO's find it hard to do prevention work with teachers not reporting crimes.

Lt. Fatooh: At one school, in the past, we felt the school was hiding information from us, serious criminal information. We told them that we couldn't work with them under these conditions. We haven't had much relationship with that school since.

We've had trouble with the reporting of sex crimes, but now we've done more trainings on mandated reporting. I think what's happened in past years is that the teachers and staff would get the information, but no one ever went through it with them step by step.

Ms. Shaffer: There's the problem of the staff not knowing what's right and wrong. People don't understand the mandated reporter law and if there are no consequences, they don't pay attention to it.

Lt. Fatooh: We've seen serious assaults in high school, and then found prior incidents with the same perpetrators in middle school.

Ms. Shaffer: What's the procedure?

Lt. Fatooh: The School Board passed a Safe School resolution. If the officer on campus is going to interview a student, and that interview could turn into arrest, it's the school's responsibility to contact the parents. If an arrest is made then the Police Department will contact the parents.

Officer Balzarini: At my school, I work with school administration on most arrests. We make every attempt to get the parent to come down prior to the arrest and work through what's happening.

Ms. Shaffer: Some parents don't know their child has been involved with the police and find out through other kids. Please make sure parents are notified. The schools are not always telling them. It's very hard as a parent, if you don't even know what's happening with your child.

Lt. Fatooh: Our task force follows this issue. There are certain schools that don't always notify parents.

Officer Adams: We're not assigned to schools, but we ask if we can come into the schools. We go through a special forty-hour training. To become an SRO, you have to like children. So when we go into the schools to talk with kids, it's not to arrest them. We're trying to find other alternatives. But sometimes we have to do an arrest. Once we have made arrest we keep trying to contact parents until we are able to reach them.

A lot of parents say they don't want their kids talking to police officers, but the kids come and talk with us about stuff they won't talk to their parents about. They like talking with us so much that sometimes we have to kick them out of the office when it's time to go. They know that we care about them, that we hurt for them.

When I came into the police department none of this was in my job description, like hugging a student. There's a student I hug every day. She has to come once a week to show me her progress report. She's made it through the second part of the ninth grade.

I want to change the way kids view us. A lot of people say we shouldn't be in the schools. But ask the kids; they want us to be there. They feel safer with us there. The majority want us there. We're not going in there to take anything from the parent.

I was one of the first to start with the program. It's not that we are forced into it. We apply for it and we go through training, because we like kids.

Mr. Luebkeman: What about anonymity and confidentiality.

Officer Adams: Yes, they can talk to us confidentially. But we tell them if they're talking about something illegal, we're going to take action. We also ask them who else they can talk to.

Mr. Luebkeman: What kind of support do you get from the Board of Education.

Lt. Fatooh: Some members of the Board of Education are philosophically opposed to the SRO program. That's softened a little bit. At first there was a push to get the SROs out of the schools altogether. Now, the focus is shifted to reviewing the MOUs. We've gotten so much support from parents, students, administrators, that the view of us has softened.

There was a proposal to have us be guards on the outside of the schools. But it's important for us to be inside building relationships with the students. A couple commissioners still don't like the program. At the hearing at Thurgood Marshall School, two commissioners took a stand against us. Coleman Advocates is opposed to us.

The Office of Citizen Complaints investigated the situation at Thurgood Marshall, and made no rulings against any officer. They thought, however, there could be some different procedures. We're trying to be proactive and not have an incident like Thurgood Marshall happen again.

Dr. Turner: Where do you get your biggest support? Who helps you the most?

Lt. Fatooh: Administrators. A good number of parents. And students who have had positive relationships with the officers. Heather Hiles supports us. MUNI supports us a lot. We need more community support. We're so busy, we don't have enough time to get out and meet with people, and do outreach. We do so much with the kids.

Member of the public: Is curfew going to start again?

Lt. Fatooh: I don't know. It's still on the books. But there is so much political opposition to it in this town.

Ms. Wilson: Are they going to ever come up with some harder consequences for students who get involved in incidents? The ones who aggravate the fights? Often there are no consequences. I was at Thurgood Marshall during that incident. I was telling students to leave. They wanted to stay and be bad, even though they were getting hurt.

Officer Adams: My girls have fights. I would take the girls when they would fight and my partner would take the boys. We look for the mess disturbers. That's who the kids need to stay away from. They don't allow the person to come talk to them anymore. If a student is stirring things up and that causes an incident, we can get them for inciting a riot. There are consequences.

I have young women coming into my office and saying, "We need to talk because I have someone getting on my case." You have to change their way of thinking. They are bombarded with TV. I asked my daughter, "Are there any videos without something negative, like guns and fights?"

You teach them: "You are the jewel from Tiffany. He can't touch you." Talking with them, working on their self-esteem changes them. Not overnight, but it does change them.

Ms. Knight: What about mental health situations regarding the police and the schools?

Lt. Fatooh: Our relationship with mental health is much better now. When mental health clinicians first came into the schools through Wellness Centers, there was a problem with sharing information. The Wellness Centers had their confidentiality policies. But if something is a very serious public safety issue, then we can share information.

We've been working a lot with CBHS the last couple years. SROs have made over 150 referrals through Project Impact, which is now over because of the grant ending. Officers would meet with the principal and get parents involved and refer them to Project Impact.

Rita Perez from CBHS is going to meet with us tomorrow morning. We come into contact with these kids who need mental health services all the time. We want to be able to be part of the support system for these kids.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services (CBHS)

Mr. Batongbacal reported for Dr. Cabaj: We had our first meetings with ZiaLogic, the consultants who are helping us with integration. One hundred and sixty program directors attended.

Dr. Moses: How much is CBHS paying them? Mr. Batongbacal: They are being paid $200,000 for two years under a SAMHSA grant.

Mr. Douglas: I went to the meeting with ZiaLogic and I was favorably impressed. I went into it wondering why we were spending precious money on them. But I was impressed. They seem to have a grasp. This is a specialized technology.

Ms. Walker: I went to it, too, with no idea what it was going to be. I was also favorably impressed. They want to get a system from the bottom up, not the top down. It was very impressive.

Dr. Moses: I'm glad some people were impressed. I wasn't. I thought they were just brainstorming, and we were educating them.

mr. martin: The re-integration of substance abuse services and mental health services, is that actually a federal prerogative? Is that why SAMHSA is making grant money available?

Mr. Batongbacal: The money is federal money, but it is not a mandate from the federal government. In the past, there has been some integration at the top, but not necessarily at the level of the delivery of services. Separate funding streams had separate eligibility requirements.

mr. martin: Those dual diagnosis specialists, are they doing outreach?

Mr. Batongbacal: They are still doing homeless outreach. There's actually further action from the Mayor. There are four priorities for him. One of them is homelessness. A committee of inter-departmental people has been put together to address the situation. I think the difference is that there is a consistency in commitment to devote the resources it will take, and one of those resources is housing. The Mayor is saying it's important to provide actual housing so people can get off the streets.

Ms. Hewson: Who are the consultants and where are they coming from?

Mr. Batongbacal: They have a lot of experience working on federal, state, and county levels. Kenneth Minkoff is well-known and has written a lot of the policy papers for SAMHSA. He's been instrumental in developing the model SAMHSA is extolling as the best practice. Christie Cline, was State Director for Mental Health for New Mexico and is very well versed in integration issues.

They don't just pat your back and say you're doing a good job. They point out your weaknesses, too.

Ms. Brooke: The one thing that impressed me, was clarifying the distinction between the administrative role and the front-line role. The administration has to integrate all the management of the services, but when a client walks through the door no individual clinician has to be an expert in all areas. They have to receive the clients in a friendly manner and send them to the right place. But it's not that everyone has to know everything.

Mr. Batongbacal: Every program has to be dually-diagnosis capable. And be able to identify what clients need.

Mr. Kalman: I have a copy of the Ten-Year Plan to Abolish Chronic Homelessness. On page 41 and the next few pages, and then page 53, the scenario is problematic, the way this document shows. They are talking about 16,000 people in the city using narcotics. I talked last evening with one of the authors of this document. He just said there's no money. It's not easy. And I don't know what can be done.

The Director's written report was distributed.

1st CBHS Integration Planning Meeting Held. Over 160 directors from about 70 CBHS agencies and CBHS Central Administration staff met last week with our Behavioral Health Integration Consultants (ZiaLogic), Drs. Christie Cline and Kenneth Minkoff, to learn about an inspiring vision for an integrated mental health and substance abuse service delivery system in San Francisco.

Christie and Ken also briefed about 60 CBHS clients, family members, peer counselors, and client advocates, as well as a combined meeting of the Mental Health Board and Treatment on Demand Planning Council, on this exemplary model of behavioral health integration ñ the Comprehensive, Continuous, Integrated System-of-Care (CCISC) model.

We are finally taking our first steps on this long-awaited journey of integrating our behavioral health services at the system, program, and clinical levels, and I am enthused by everyone's attendance at these initial meetings.

In work sessions facilitated by ZiaLogic, the CBHS Executive Team has also begun to map the contours of a planning and implementation process that will take place over the course of the next year. In the next month, the CBHS Executive Team will complete its internal preparations to launch this integration planning initiative with our CBHS system partners.

The behavioral health integration process over the next few months will include the following three key elements:

Constitution of a core advisory team that will steer the system design and implementation. This team will have, at minimum, representation from children/youth and adult/older adult providers, mental health and substance abuse providers, CBHS/DPH administration, and clients/family members/advocates, and will be the formal advisory body to the CBHS Executive Team on the integration process.

Drafting of a Consensus Charter Statement on Behavioral Health Integration. This will be worked on by the core advisory team, with input from the rest of the system. This document will be the CBHS system-partners' collective statement of our vision for integration, as well as contain the concrete action steps that will be taken by each of the partners to make this vision a reality over time.

Development of regular forums to facilitate participation of all stakeholders in the planning process. This would include regular dissemination of updates and a systematic solicitation of everyone's input. Methods to be employed may include regular e-mail updates or a newsletter, as well regular inclusion of this agenda at all of CBHS' standing work committees and advisory bodies. Questions and input about this unfolding integration process can also be communicated at any time to CBHS Associate Director Edwin Batongbacal at edwin.batongbacal@sfdph.org or at (415) 255-3446.

Also over the next few months, CBHS will begin to avail of the following technical assistance resources from ZiaLogic:

Train-the-Trainers. Agencies interested to be in the lead of this integration planning process will receive 'Train-the-Trainers' technical assistance from ZiaLogic, which is aimed at developing a cadre of trainers throughout the system, with integration expertise to assist agencies from within.

ZiaLogic Integration Toolkits. These evaluation instruments are actually educational tools designed to engage the whole agency, and individual clinicians, in a discussion and examination of the various aspects of their co-occurring disorders capability at the system, program, and clinician practice levels. Within the next 6 months, ZiaLogic will begin training on the use of these instruments.

The CBHS Executive Team looks forward to forging a true partnership with all stakeholders in embarking on this significant project of making the CBHS system of care relevant to the needs of all of our clients. This work needs everybody's input and involvement. The CBHS Executive Team will be committed to fostering this participatory process, as well as to addressing administrative or system obstacles identified as hampering the provision of quality, co-occurring disorders capable services.

The next visit of Christie and Ken to San Francisco will be on the week of December 6, 2004. I look forward to the steps we shall be taking in these next three months prior to their next visit.

2. **Substance Abuse Recovery Celebration.** In recognition of the 15th Annual National Alcohol & Drug Addiction Recovery Month, the San Francisco Association of Alcohol & Drug Program Contractors is sponsoring a celebration on Thursday, September 30th at Glide Memorial Church featuring national spokespeople and local residents, sharing recovery success stories and highlighting the importance of treatment programs.

Celebrations at Glide Memorial Church will begin at 2 p.m. in the auditorium and admission is open to the community. Confirmed keynote speakers are Dr. H. Westley Clark, Director of the Center for Substance Abuse Treatment, and Kathy Jett, Director of the California Department of Alcohol and Drug Programs. They will both address the critical issue of recovery and the importance of community in sustaining positive recovery. Henry Lozano, Co-chair of the President's Advisory Commission on Drug-Free Communities, is also scheduled to speak.

A diverse selection of entertainers who will appear include renowned performer Rhodessa Jones as master of ceremonies, the Recovery Theater, Buena Vida Salsa Club, Teen Challenge Choir, the Straight Forward Club, and Katie Rubin's one woman show "Insides Out."

During the month of September, communities nationwide are helping people recognize that alcohol and substance abuse and addiction are treatable diseases and that treatment is as effective as treatments for other chronic medical conditions, such as diabetes and high blood pressure. Recovery Month also celebrates the successes of individuals who have engaged in treatment and recognizes men and women in the treatment field who dedicate their lives to helping those with addictions. This year's theme is "Join the Voices of Recovery: NOW!"

The Recovery Day celebration is co-sponsored by SAMHSA Center for Substance Abuse Treatment, the San Francisco Community Behavioral Health Services, Glide

Memorial Church and Unity Foundation. The celebration is supported, in part, by a grant from the U.S. Department of Health through CBHS.

3. **Community Vocational Enterprises (CVE): Outcomes and Incomes Project.** Since 1999, CVE has engaged BTW Consultants to measure CVE client outcomes. BTW conducts interviews of CVE clients on an ongoing basis and tracks outcomes. The findings show that CVE programs have yielded impressive results for the over 400 clients served annually. For example, 17-28 months after clients start employment in a CVE business enterprise, 71% are still employed following graduation from CVE. The income mix of CVE clients also changed significantly. Prior to hire in a CVE business, 77% of clients' monthly income came from public benefits. Seventeen to twenty-eight months after hire only 23% of their income came from public benefits. During that time period, hourly wages went from an average of $6.27 to an average of $9.40 per hour. At the same time, CVE's own client satisfaction surveys show that clients are highly satisfied with our services. In an anonymous questionnaire, clients rated CVE services at the top rating of 4 on a scale of 1 to 4. As a result of BTW's ongoing outcomes tracking, CVE will continue striving to improve vocational services for clients to better assist them in their path to recovery.

3.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke I'm impressed with how many MHB members showed up at the meeting with the ZiaLogic consultants last week.

The next Police Crisis Intervention Training will be October 18-21. We're also collaborating with the Police Department on a video for desk clerks, property managers, and staff at SRO hotels and residential facilities so when they call the police they can know what to say to them and can make sure there is an effective intervention.

My son is now serving in Afghanistan and I'd like to ask for prayers for him and all the military over there.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee

ELECTION
Mr. Stinson: I've found a new job in Mountain View. So my wife and year-old daughter are moving down there. And that means I have to leave the Mental Health Board.

I want to let you know how much I've learned form each and ever yone of you. I came to this board knowing nothing, but I learned from all of you and from the guests we had and the staff of CBHS. I came away with a profound respect for different people's experiences and viewpoints. We didn't always agree, but I think we always engaged.

Thank you for being here. Nothing says you have to do this. I think you don't get told thank you often enough.

I have a very optimistic view on what we can do and what we can accomplish. Mostly it's a war of attrition. There are no easy wins. Proposition 63 might be an exception. But usually, it's one small thing at a time, one conversation at a time. If you step back and look at what's happening over time, you can see the progress.

Finally, I want to share a huge thanks for Rich and Helynna, as I think about the support and the commitment and dedication you two have shown to your jobs. If you hadn't been here I don't think I would have made it through the first two meetings. You give public service a great name. Thank you both.

Dr. Moses: I want to thank you for the precious time you were with us. I appreciate how you run meetings. Your sense of humor is so dry and so sweet. The meeting you got with Mayor, you ran beautifully. Thank you for bringing us together and for your professionalism. We will miss you very dearly.

ELECTION OF THE NEW CHAIR
Mr. Stinson: Toye, Bridgett, and myself were the Nominating Committee and are recommending Rebecca Turner to be the next Chair. You are also free to nominate others, including yourself, to be Chair.

There were no other nominations.

RESOLUTION (MHB-2004-30): That the Mental Health Board elects Rebecca Turner to serve as the Chair of the Mental Health Board and to fill the unexpired term of Ted Stinson through February 2006. (Passed unanimously.)

5.0 NEW BUSINESS
Ms. Shaffer: I'd like to support SRO's and do some follow up since this is related to one of our goals this year.

Mr. Douglas: I've been representing the Board at the CALMHB meetings. The next one will be in Oakland, the last week this month. Any of you can go. It's really interesting.

Ms. Kellum-King: On May 21, 2005, the National Alliance for the Mentally Ill-SF will be hosting their first walk. It will be three miles in Golden Gate Park. We're raising money for mental health services.

6.0 PUBLIC COMMENTS
Mr. Kalman: Thank you, Ted. Don't forget us!

7.0 ADJOURNMENT
There being no further business, the meeting was adjourned at 8:27 p.m.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD
Wednesday, October 13, 2004
1380 Howard, Room 537
6:30 p.m.

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AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of September 8, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of October 13, 2004, to the following members: none.

2.0 PRESENTATION: MENTAL HEALTH SERVICES FOR HOMELESS WOMEN AND CHILDREN (50 minutes)
For discussion.

Alisa Birgy, Program Director, Ashbury House, Progress Foundation
Pat Harrison, Program Manager, Episcopal Sanctuary, and
CEO, Holistic Multi-Purpose Sanctuary
Sai-Ling Chan-Sew, Director, Children, Youth and Families Section, CBHS
April Silas, Director, Homeless Children's Network

2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

3.0 DIRECTORS REPORTS (20 minutes)
For discussion.

3.1 Report from the Director of Community Behavioral Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.
Discussion of budget policy and strategy.

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

7.0 ADJOURNMENT

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1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

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Department of Public Health

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MEETING NOTES
Mental Health Board

Wednesday, October 13, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Rebecca Turner, Ph.D. (Chair); Supervisor Bevan Dufty; Carol Knight, M.A.; Joel Luebkeman; Michael Medema; Idell Wilson; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Bridgett Brown; LaVaughn Kellum-King; chance martin; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Ted Stinson;

BOARD MEMBERS ABSENT: Augusta Del Zotto, Ph.D.; Bob Douglas, J.D.; Kate Walker; Dennis Yun, M.S.W.

PRESENTERS:
Alisa Birgy, Program Director, Ashbury House, Progress Foundation
Pat Harrison, Program Manager, Episcopal Sanctuary, and CEO, Holistic Multi-Purpose Sanctuary
Sai-Ling Chan-Sew, Director, Children, Youth and Family Section, CBHS
April Silas, Director, Homeless Children's Network

OTHERS PRESENT: Robert Cabaj, (Director, Community Behavioral Health Services); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

PLEASE NOTE: There was no quorum for this meeting. Therefore, no action items were voted on and no votes of any kind were taken.

1.0 CALL TO ORDER AND CONSENT CALENDAR
The meeting began at 6:40 p.m., facilitated by Rebecca Turner, Chair.

Dr. Turner: I'd like to welcome Michael Medema to the Mental Health Board. He was appointed by Supervisor Bevan Dufty to a Public Interest Seat.

Mr. Medema: Thank you. It's great to be here. Not only am I in the public interest category, but I'm also a provider. I worked for Walden House HIV Care Unit working with people who had dual and triple diagnoses. Then I worked for DPH for the

Treatment Access Program of the Department of Public Health. Now I'm a tenant services supervisor for Community Housing Partnership. Also I could be considered a consumer.

I'm very interested in mental health and homelessness as well as mental health and substance abuse, especially speed abuse. Also I'm very concerned with access, and that people get the services they need and not be turned away.

2.0 MENTAL HEALTH SERVICES FOR HOMELESS WOMEN AND CHILDREN

Ms. Harrison: It's a privilege to be invited back to this room. I spent a lot of time in this room as a member of the Mental Health Board. So it's like coming home to family.

A few facts about whence I come. I am still a Mississipian born and raised. Since 1966, I've worked with people who are marginalized. I moved here to San Francisco in 1989. I worked for Glide Memorial, where I developed programs, and directed the Crisis Center for 5 years. Then I went to work on developing the new shelter model the City was putting together. I then worked at Next Door, a multi-service center for the homeless. Then they asked me to go to the Sanctuary to make that work as well.

By choice, I have been an advocate. It's just been great to be paid to do something you love. This topic of homeless women and children is so very, very important. I work with a lot of single adults who are re-unifying with children. These are people who are trying to rebuild their lives.

One population, which is not being ignored, but which is not given enough emphasis, is homeless women who are seniors.

We just lost a lady who was homeless and going from shelter to shelter for the last seven years. She was in her mid 80s and Asian. She had income and didn't have to be homeless. But her son has a serious drug problem and she used her money to help him get drugs. This kind of thing is happening to others. There are many women who have adult children who are abusing them.

At this very moment in the Sanctuary, I have at least 30 women who are in the situation of trying to get their children back and make amends with their children, or those who are acting as an enabler for their adult children.

This is causing another problem for those women, a huge substance abuse problem. It's not always illegal substances. I've watched three women in the last year take their own lives by using prescribed medications.

This is just me speaking. The City is being upbeat about getting housing for the seniors in the shelter system. But my seniors are sitting there saying, "We're not going anywhere." I've seen them decompensate when we stick them in housing. In our zest for getting homeless people housing, we have to remember that housing alone is not enough. Supportive services are needed along with the housing.

Ms. Birgy: I'm the Program Director of Ashbury House which is part of the Progress Foundation. I agree with Pat, that housing alone is not enough. So we provide treatment first, in order to help people be able to live independently. Our agency also runs programs for seniors, so call me and I'll connect you with our programs.

Progress Foundation runs 11 or 12 residential facilities. Ashbury House is for women and children. There was a woman we started working with who came out of the hospital and was separated from her child and was depressed in response to this. Ashbury House was started in 1995, and we're now coming up on our 10th anniversary.

We have 24-hour treatment with two staff present all the time, plus a day curriculum. We have a specialized parenting program for women with children. We have instituted Dialectical Behavioral Therapy (DBT), a new treatment for people with impulse disorders. We have a lot of ADL groups, meaning Activities of Daily Living. We work closely with CPS workers. We work closely on reunification plans so the women can get their children back. We provide a lot of support services for our kids. A nurse practitioner is there to deal with health issues.

At any time, we can have ten moms and ten children.

Working with women means having a home-like environment, building a strong relationship with them before getting movement. The length of time we have with them helps us to get to know them. We focus a lot on trauma as well. That's why we started using DBT, because it works well for women with a history of child abuse and other trauma.

We need to be able to be flexible in response to women's needs. We have mostly women staff. We have one counselor who is male, but having mostly women as staff works well.

In terms of recommendations:

There is a need for family supported housing in safe neighborhoods.

We're opening La Playa House out by the beach, with onsite services. We came up with the plan by talking with the women at Ashbury. This is a small 14-unit project. And we need much more. We need to give subsidies to nonprofits to make it possible to afford this kind of housing.

Our Executive Director is trying to find a way for the kids to have programs as well. If it weren't for Ashbury the kids would be in foster care.

The Mental Health Board could advocate for funding. In the single adult system there is the system of co-operative apartments, which is ideal. It would be great if we could set up co-ops where a couple women could live together with their kids.

It would also be important to raise the issues of women and reunification with clinicians in the system. Not all clinicians pursue this issue, for example, if a mom has lost her

children three years ago, the clinician needs to ask, "Do you want them back?" They need to do grief work with these women about children they've lost.

They need to understand the parent-child dyad, and that treatment really works. It can impact the quality of parenting with the moms and they can do really well.

Ms. Silas: It's an honor being asked to speak here. I think it is a best practice, to create one coordinated system instead of having so much fragmentation. We need a unified vision for our work and we need to coordinate our strengths.

I'm the director of the Homeless Children's Network, a collaboration of 34 agencies of all types. What I enjoy about that is that we sit at the table with providers, partnered with parents and partnered with youth as active leaders in shaping the mental health interventions we use and in evaluating if the services are working or not working.

Key aspects of our programs include:

Mental health services. We work with 34 agencies and provide mental health services both at our offices and out at the shelters. We do as much therapy in the playroom and in the hallways as in the case manager's office. Some women don't feel comfortable meeting in the shelter space, and prefer to meet some other way, for example, going out for a walk. Flexibility is essential and that's what we're known for.

Child care consultation. This is our outreach to providers who work in children's centers. We support case managers and program directors who are so overwhelmed. We work with the kids in classrooms or in settings with volunteers who have very little training. We bring our consultation to help design and manage the program. We work on how to implement strategies. For example, we might help a program set nap time earlier in the day instead of having two year olds go for ten hours straight. We focus on the special needs of homeless children.

Family support, parent training, and life skills education. Flexibility again is really the key to a service plan.

Outreach to children and women and youth in permanent and supportive housing. It's so important to work collaboratively. The way people come to the table is changing. We came to the table with nine sites, because they invited us in. They checked with their constituents. The face of our services is women, women of color, women who speak different languages, and women who have come through similar experiences of homelessness and exemplify healing and health. We develop collaboratives that are called on by the constituents, rather than us always going to them first.

We believe best practices include the following:

Working collaboratively. We really take that to heart, and urge the Mental Health Board to put your funding priorities on collaboratives that are already in place.

We're going to see a lot of collaboratives popping up. But we urge you to focus on the collaboratives that have been in place serving thousands of clients for many, many years.

For example, I do not intend to make a move to support seniors without calling Pat and coordinating our work. We need to create hubs of good news, places where parents can get a series of needs met. Any door should serve a mother. Any door. It's important to centralize our support of each other.

Work non-judgmentally. It's important to look at how a lot of women have been carrying the stigma of being homeless and of being bad parents, and having low self esteem. The mother is holding the sole responsibility.

Culturally-optimal services, not just culturally-competent. You start with competence, but we want to get to the optimal level. Listen to these women talk about how many years they have had to apologize for their cultural differences in order to get their needs met.

Being compassionate with each other in providing services. Compassion begins and ends with questions, rather than making assumptions.

Count focus. The number of women in treatment is so low compared to the numbers that are out there needing treatment. There's a feeling that there is invisibilizing of homeless women. We need to make them visible and make their needs visible.

Constituents drive services. We need services that come out of the hearts and minds and souls of the people we serve. And we need policies that reflect this.

Our recommendations to the Board include:

Focus on services first. There is so much attention given to housing first, and it can be at the expense of services. But we need services at the front end and the back end. Women have said again and again, "I was in a house, but I left the house because he battered me. And I need the services so that I don't go back into a house with a destructive person."

Hold that we are a unified body. There is an idea that many people hold that providers are separate from parents. But at the Homeless Children's Network, we have dedicated our lives to shifting that way of operating. Let us build holistic plans and see each other as valuable components and collaborators.

Ms. Chan-Sew: April is one of my first teachers about homelessness. I respect her experience and compassion. When we first started going to the Homeless Children's Network, we were educated about the gaps in service and how little was being done for homeless women with children.

Now we are working with HCN, April's organization. We are providing funding for support for children, so services can follow the children from place to place. We don't want to stop services because a child moves from one program to another.

HCN served 259 children in the last fiscal year, which is quite a large number for the size of their agency.

There is funding from the First Five Commission to provide services to children under five in shelters. We work with 6 shelters and bring in mental health clinicians. This has been very productive. This is our third year of that project. We've worked with 590 children. We provide consultation to the parents and to shelter staff.

Ms. Chan-Sew then handed out:

1. Overview of the Homeless Mental Health Initiative and Its Outcome.
2. Annual Narrative Report: Homeless Children's Mental Health Initiative (Fiscal Year 2003-04)

In the first report you see the comparison of children in homeless shelters and other children in the general population. In every single category, the stressors are much, much higher for homeless children than children in the general population. This is a very strong argument for more services. The stressors include things like family instability, family economic hardships, child witness to violence, separation, traumatic stress, loss of caregiver, caregiver substance abuse, possible abuse, etc.

The Charles and Helen Schwab Foundation has a report on Homeless Children which says that there are 1500 to 3000 homeless children in San Francisco.
(For the report, go to: http://www.schwabfoundation.org/index.php/articles/638)

The School District can only count 500 homeless children. So there is a big gap. This Schwab plan talks about how the City and the schools can work together, and about having a contact person.

Ms. Knight: Thank you all for coming to our meeting tonight. I'm a native San Franciscan. How did this all happen? I remember the homeless in the 70's with the homeless encampment in the Civic Center. I grew up where you could get a three bedroom flat for $100, and now it costs thousands. I admire you for the work you do.

Do you find the women you work with have a history of being in residential care as kids? I've done a lot of work with pregnant teens. I've seen that they need a transition plan and services instead of group homes kicking them out at age 18. How many of the women you work with are from San Francisco, and how many from other states, or from California outside the Bay Area.

Ms. Harrison: You're kind of giving the answers to your questions as you speak. For instance, when I was working with the City, most of the homeless here were not from San Francisco. People came here because we give more money out. In Mississippi you can have 50 kids and still you only get $150 a month. This is now, in 2004.

There is a dilemma. When I was the support center director at Next Door, I found that the women were the hardest homeless to find. Women often take their kids and sleep on a girl friend's floor. How we feel stigma around mental health, that same kind of stigma is felt around homelessness. It is so traumatic. I have such respect for these women. I don't know if I could do what they do to survive.

Back in Mississippi, when there were 500 homeless people, the state was up in arms. The poorest state in the union and now there are no homeless there. Here we are the richest city in the world, and we have so many.

Ms. Birgy: We keep statistics on women who were in foster care and group homes. The number was 30% last year, but it's usually higher, more like 40%.

Ms. Chan-Sew: And don't forget those women who have been exploited sexually. There are plenty of them too.

Ms. Birgy: Probably 98% of my moms were abused as children.

Ms. Knight: My grandmother just made 96 last year. With seniors, moving from environment to environment can be very stressful. With your seniors, are you having mentoring or support services. They don't like to be alone in the transitions.

Ms. Harrison: I'm fighting with the City. They know me. Seniors need services at the beginning and the end of transitions. As MHB members, I hope you take some time out to consider the trauma in the lives of these women. Including the senior women. I have six women in diapers. And still their kids come by to get money from them.

On the flip side, there are so many successes with all of us working together. If you really look at the picture, no group is doing it alone. As MHB members, I hope you will venture out to look at some of the models that work. The Next Door model, the shelter model. We say to people who come to us, if you are not interested in getting out of homelessness you're in the wrong place.

We sit on the Homeless Board, made up of a lot of corporate people, but they haven't visited the shelters. It's their not wanting to know that bothers me. If you can get the opportunity to visit the Next Door shelter you can see that San Francisco is doing it right. It's a great model. If you want to do a tour as a group or individually, let me know.

The next two models I suggest are:
1. The Cecil Williams Glide Community House
2. Cannon Barcus House of Episcopal Community Services.

These are two amazing places with services on site. That's the key. There are mental health and substance abuse workers with the people all the time until they are ready to stand on their own.

I see some amazing results, like a homeless mom and little boy, where the police took the boy to a psych ward. They are now in the Cecil Williams House. The boy is now

making straight A's, reciting poetry, and has a poem in a book published this year. That's why we do this work.

Mr. Medema: I've sent people to all your services before, so thank you. I have two therapists who come to my site where I work now from the Homeless Children's Network. When I worked at Walden House, we had a much tougher time getting women into treatment than men. What are the obstacles?

Ms. Birgy: If there are a lot of men and few women in a treatment center, a lot of women won't go there. A lot of women won't go into treatment where they are going to be separated from their children.

Ms. Harrison: There are some things that money can't buy. I was part of the Treatment on Demand Council for five years. Our treatment system is still more for men, and women have special needs. You have to find the right people who can connect with the women, who are sensitive to them especially when it comes to reunification.

I teach women to say, "I want a change," when their services are not working for them.

Ms. Chan-Sew: The system hasn't treated women, especially women with children, very well, and people know that. Women are afraid. There is so much harm the system has done to women. The first thing they think is that the system is going to take their kids away. It's a common story.

Ms. Silas: Women tell us, "I have so much at risk by entering treatment." So we have to deal with that directly and help them get through that. Women have learned how to survive by living a lie, and putting up the false pretense. They will present as a great mother, but don't show the real pain they are holding and the real trauma they are holding.

Ms. Birgy: Women need a lot of validation first before working on change.

Mr. Luebkeman: Relative to the foster care system, are there times when the separation is the best thing, even though it must be traumatizing?

Ms. Birgy: Yes, there are times when treatment is not enough, and the mother is still dangerous around kids, or the kids are at great risk of neglect. We try lots of interventions first, and then if those are not working, that's when you have to make such a move.

Ms. Silas: I want that child to stay with that parent, but first the overall health of family has to be taken into account. It happens alot.

Scott Clark: I'm on the Surplus City Property Citizen Advisory Committee. Our first meeting is the 20th of this month from 3-5 at City Hall, Room 201. We are lobbying the City for that surplus property to help homeless people. It's probably going to be homeless-oriented and probably secondarily family-oriented. There is a state grant coming up with a family focus.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services (CBHS)

Dr. Robert Cabaj: The written report is fairly lengthy. It seems like we do more and more every month. I don't know how, but somehow we do.

We've had the big consultation with our integration consultants called ZiaLogic. We've started our integration Work Group. Three working groups will steer the project through to completion. I'm very excited about how this process is going.

Proposition 63 planning has already started. We had an initial stakeholders meeting last week, with consumers, family members, and providers, in case Prop 63 passes.

Today was a homeless outreach day. Seventy-five DPH staff, including administrators, walked the streets connecting with people who seemed to be homeless to ask them if they wanted services, and then linked them up if they wanted that.

Ms. Harrison: I was late coming here tonight because of your outreach today. I was making appointments with people who came in because of that outreach.

The written Director's Report was distributed:

1. CBHS Integration Rolls Out. A Behavioral Health Integration Implementation Workgroup has been formed within CBHS central administration to conduct the planning, implementation, and provision of support to programs (technical assistance and system-change), towards the integration of mental health and substance abuse treatment services. This central administration workgroup will be chaired by CBHS Associate Director Edwin Batongbacal, and will soon break into committees to carry out its work.

A 15-member Integration Advisory Committee is also being constituted, and will have its first meeting on October 15. The Advisory Committee is the representative stakeholder group that will advise the Workgroup and the CBHS Executive Team on all aspects of integration implementation. The Committee will be composed of representatives from the Treatment on Demand Planning Council, Mental Health Board, Mental Health Contractors Association, SF Association of Alcohol & Drug Program Contractors, CBHS Client Council, CBHS Adult/Older Adult and Children, Youth & Families Systems-of-Care, and staffed by representatives from CBHS central administration.

All stakeholders throughout the system will be able to exert influence on the integration process, and this will take place not just through the Integration Advisory Committee alone. CBHS envisions empowerment for all partners in this integration effort, through a multiplicity of mechanisms, as follows:

The Advisory Committee and Implementation Workgroup will incorporate all input, suggestions, and feedback from everyone in the system.

Each individual mental health and substance abuse program will work closely with their CBHS program monitors, and receive technical assistance and support for their work of evaluating, planning, and implementing steps toward making their services more dual-diagnosis capable. Towards this end, CBHS central administration will commit to address system barriers that are identified by programs.

All existing CBHS advisory councils, workgroups, committees, and divisions will actively contribute ideas, input, suggestions, and feedback that will materially influence the plans for integration. As important, they will also creatively carry out each of their parts of the integration implementation.

Each team member of all CBHS agencies will contribute in various ways towards making their own agencies dual diagnosis capable. This includes forwarding quality improvement and system-of-care suggestions for the system as a whole.

The input of clients and family members will be actively sought.

The following are the most immediate integration activities the CBHS system will embark on in the next few months:

System-wide education of all staff of all CBHS agencies on the vision of a Comprehensive Continuous Integrated System of Care Model.

System-wide and participative drafting of a Consensus Statement towards integration.

"Train-the-Trainer" program for a cadre of trainers recruited from throughout the system, which will develop integration expertise to assist CBHS agencies from within.

Training on the use of the educational ZiaLogic Evaluation Toolkits, and beginning use of these instruments across the system. Chris Cline of ZiaLogic will visit us on November 10 to videotape a training on the use of these evaluation instruments, which will then be disseminated to all. (These evaluation tools include System-level COFIT, Program-level-COMPASS, and Clinician-level-CODECAT.)

I look forward to all CBHS partners moving together in this worthwhile effort. A very important part of our system, second only to clients, is our providers. We hope, that through this integration effort, the system can be transformed to support providers better in their much-appreciated efforts of giving the best services possible to clients.

2. Project Connect Outreach to the Homeless. On October 13, seventy-five (75) CBHS staff-members will fan out onto the streets of the Tenderloin and South of Market, as part of 250 Project Connect volunteers assembled from various city departments to do a one-day outreach to the homeless. The purpose of the exercise is to sensitize City staff and the community to the needs of the homeless, and to survey what these needs are. Homeless individuals encountered by the volunteers will be provided connections to various housing, health, and human services. This is not just a one-time effort, but is part of furthering the City's overall strategy and ongoing efforts to end chronic homelessness.

3. 1st Monthly Meeting of Substance Abuse & Mental Health Adult/Older Adult Providers. Starting on November 5, CBHS substance abuse and mental health adult/older adult program directors will begin to meet together regularly every first Fridays of the month, 9 - 11 AM, at DPH, 101 Grove St., Room 300. This is a very important development in the integration of our behavioral health services system! Congratulations to all those involved in this undertaking. For more information, call Linda Wang, Director, CBHS Adult/Older Adult Systems-of-Care, at (415) 255-3421, or Jim Stillwell, San Francisco Alcohol and Drug Administrator, at (415) 255-3717.

4. Dual Recovery Anonymous. Dual Recovery Anonymous is now up and running in San Francisco, thanks to the work of Stephen Dempsey of CBHS Client Relations. Dual Recovery Anonymous is a peer support group for people with co-occurring mental health and substance abuse issues, and is based on the 12-Step model. There are two Dual Recovery Anonymous meetings that have already started, and Stephen is available to help programs start DRA meetings at their sites. For more information, please call Stephen at (415) 255-3664. DRA also has a website at www.draonline.org

5. Grant to Expand Meth Treatment. CBHS has been awarded an annual $500,000 three-year Targeted Capacity Expansion grant for Methamphetamine Treatment by the Federal Center for Substance Abuse Treatment. The new program will be a collaboration between Stonewall/Magnet, STOP, Continuum, and CBHS to replicate and evaluate the successful UCSF methamphetamine treatment model in the Continuum setting.

6. Recovery resource for all ages. Last month marked the one-year anniversary of a support group for individuals with schizophrenia and schizoaffective disorders. The group, which was initiated by Susanne Killing (Nurse Practitioner at Central City Older Adults Clinic) and a consumer, embodies a recovery and consumer-focused treatment model by offering peer and professional co-facilitators. The group arose out of an unmet need in the community. While working with family members of the mentally ill, Susanne received numerous requests for community resource referrals, and was frustrated to discover that, while there are community support groups for individuals with anxiety, depression and bipolar disorder, no such resource existed for those with schizophrenia.

Susanne and the consumer group co-leader are both committed to the recovery and wellness model of mental health treatment. Those who attend the group find a safe and supportive environment to discuss their struggles and successes while living with schizophrenia. Frequent topics of discussion at the group include: symptom management, vocational rehabilitation, homelessness, and the stigma of having a mental health diagnosis. The group meets monthly at 1380 Howard Street in the 5th Floor Conference Room, and is open to all individuals of all ages with schizophrenia or schizoaffective disorder. Participants do not have to be consumers in the county mental health system or clients at Central City Older Adult Clinic to attend. For more information, or to receive a flyer, call Susanne Killing at 415-558-5900.

7. DMH Annual Compliance Audit. During the week of October 18 - 22, California Department of Mental Health will conduct its annual on-site Compliance Audit of the CBHS San Francisco Mental Health Plan. Programs will be visited; system-wide

policies & procedures will be reviewed; and consumers, family members, service providers, and administrators will be interviewed, as part of this audit. Thank you to Kevin McGirr of Quality Management for leading CBHS preparations for this audit.

8. **Recovery Day.** Over 200 people attended a successful Recovery Month celebration at Glide Memorial Church, held September 30 in recognition of the 15th Annual National Alcohol & Drug Addiction Recovery Month. Thank you to Tina Yee, Director, CBHS Cultural Competence and Client Relations, and to Jim Stillwell, CBHS Alcohol & Drug Administrator, for working on this event.

3.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke: Next week we're holding the 11th Police Crisis Intervention Training.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee
Dr. Turner: We'll be holding the Annual MHB Retreat on Saturday, December 4th. We'll be setting our priorities for 2005.

As the new Chair of the MHB, I'm going to be phoning everyone to get to know you better, and find out what you're interested in.

5.0 NEW BUSINESS
No new business.

6.0 PUBLIC COMMENTS
Ms. Wilson. I'm going to be doing an all men's show on my TV program.

7.0 ADJOURNMENT
There being no further business, the meeting was adjourned at 8:10 p.m.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, November 10, 2004
1380 Howard, Room 537
6:30 p.m.

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AGENDA

Public comments will be taken for each agenda item.

10-13-04A10:39 RCVD

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of September 8, 2004, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of October 13, 2004, be approved as submitted.

1.2.c PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of October 13, 2004, to the following members: Ted Stinson, Dorothy Shaffer, LaVaughn Kellum King, Bob Douglas, Toye Moses, chance martin.

1.2.d PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of November 10, 2004, to the following members:

2.0 PRESENTATION: DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES (50 minutes)
For discussion.

Margaret Brodkin, Director of Children, Youth and Families, formerly Executive Director of Coleman Advocates, will present the departments goals and direction.

2.1 Discussion of Possible Future Actions Related to Presentation (10 minutes)

3.0 DIRECTORS REPORTS (20 minutes)
For discussion.

3.1 Report from the Director of Community Behavioral Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

3.3 Mental Health Board Budget Update

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee. Discussion of budget policy and strategy.

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

7.0 ADJOURNMENT

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD). Five days notice before the meeting will help to ensure the presence of an ASL interpreter or sound enhancement system. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 14 Mission. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

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Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES
Mental Health Board
Wednesday, November 10, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Rebecca Turner, Ph.D. (Chair); Bridgett Brown; Bob Douglas, J.D.; Supervisor Bevan Dufty; LaVaughn Kellum-King; Carol Knight, M.A.; chance martin; Michael Medema; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Idell Wilson.

BOARD MEMBERS ON LEAVE: Toye Moses, Ph.D., M.P.H.; Joel Luebkeman; Sandy Yuen.

BOARD MEMBERS ABSENT: Augusta Del Zotto, Ph.D.; Ted Stinson; Dennis Yun, M.S.W.

PRESENTERS: Margaret Brodkin, Director, Department of Children, Youth, and Families

OTHERS PRESENT: Edwin Batongbacal (Associate Director, Community Behavioral Health Services); Rob Wheeler (Mental Health Association of San Francisco); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:38 p.m. by Rebecca Turner, Chair.

Dr. Turner: First we have an invitation from Rob Wheeler of the Mental Health Association. The MHA led the successful campaign for Proposition 63 in San Francisco.

Mr. Wheeler: On behalf of the Mental Health Association, I wanted to express our appreciation for our partnership with the Mental Health Board, and for your help in passing Proposition 63, the Mental Health Services Act. This proposition promises to bring significant money into San Francisco for much needed new services.

We now have an opportunity to transform the mental health system in the state of California. I want to thank the individuals on the Board who worked on the campaign. We're throwing a thank-you celebration next Thursday evening, November 18th from 4-6 in the Mayor's conference room and you're all invited.

2.0 PRESENTATION: DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

Dr. Turner: Margaret Brodkin was the Executive Director of Coleman Advocates for 26 years, developing the organization into being the foremost advocacy group for children in San Francisco. She is known for arriving at City Hall with hundreds of parents and children behind her to speak about children's needs. Wisely, Mayor Gavin Newsom made the decision to appoint Margaret Director of the Department of Children, Youth and Families (DCYF) and bring all of her years of experience on the front line to benefit the City.

Ms. Brodkin: I've only been on this job three weeks, so I don't have a formal structured plan. I'm as surprised as anyone else that I got appointed to this position. It's unusual for someone who is an advocate and who is used to marching on City Hall, to get appointed to run a department like this.

Our work through Coleman Advocates created the department. Back in the days of Art Agnos in the late 80's, we set up the children's department. The Children's' Fund, which is $25 million per year, is overseen by DCYF.

I feel the Department has several major functions. One of which is to make sure the money in the Children's Fund is spent wisely. I spent part of the afternoon in the mayor's budget office listening to all the cuts we are supposed to make. This is very hard for an advocate like myself, especially to hear the cuts to family child care providers, who are the lowest paid people in world. They would need a 25-cent raise to bring them up to the city's minimum wage. I find that kind of sick how the city chooses to spend so much money on less important things.

With the passage of Proposition 63, there will be new money coming in for the first time in a long time.

Sophie Maxwell had a hearing on children's mental health and passed a resolution on Monday calling on the Department of Public Health to have a discrete planning process for children's mental health, and I will likely be chairing that sub-committee with Sai-Ling Chan-Sew, Director of the Children, Youth, and Families Section of Community Behavioral Health Services. We'll be looking especially at prevention and mental health services in the schools.

With regard to the Wellness Centers, we don't have them in any middle schools, the small high schools, or the county schools—where the children who need them the most are. We're moving in the direction of a carve-out for children, with a focus on prevention and schools. This is the kind of role this Department can play as an advocate and convener, to see that things are done right to meet the needs of kids.

Some of the things I'm working on now include:

The summer food program: I'm clearly interested in seeing children get fed. We're working to expand that program to after school. We want to make sure all our families with children get all the benefits they are entitled to.

The Mayor has agreed to put money into a local earned income tax credit, which is miraculous. If you earn under a certain threshold, you get money back. so every family who is eligible for that at the federal level will also get a check for it from the city as well. It's amazing for the Mayor to do that.

The strategy is that families need it, and it also puts money into the city's economy.

We will be trying to reform Log Cabin Ranch. I was at Coleman Advocates for 26 years, so I've been through every battle. There has never been a really good program at Log Cabin Ranch. The Mayor has said he is committed to seeing that program restructured.

I'd like to bring in a nonprofit, a quality mental health provider. The Probation Department has had a lot of difficulty running a quality program at the Ranch. A nonprofit provider could draw on state funds. We need to fight to see that whatever money gets saved, gets pumped back into the mental health and child-serving system.

I took the initiative to get the City to set up a task force on child nutrition and obesity. We are very interested in places where children can get exercise, especially since they're going to be closing 11 recreation centers due to budget cuts. I'm very interested in seeing that children have places to go and get exercise. I'd like to see the rec centers changed so they become more community-owned places.

At DCYF, we are in a position to troubleshoot issues as well as implement new ideas. So you should know you can come to us. We are interested in all aspects of children's health and welfare. We have staff embedded in all kinds of departments around the city.

I have been supportive of the Superintendent of Education and want to work to help make the Dream Schools work.

There are 220 community organizations which are funded through the Children's Fund, so we are in a position to ensure the quality of services and the improvement of services. Some agencies are terrific. Some are less than terrific. Children deserve quality programs. DCYF has people who are monitoring all 220 children's agencies.

These are some of the things we're working on. I don't have a totally coherent plan yet.

There are two events I want the Department to sponsor every year.:

1. Network Conference. A place where all the agencies serving children come together tp hear from the Mayor, hear from the department heads, learn from each other, and have input into city plans. This would be held in March.

2. Coleman Advocates has been running Family Fest, a celebration of the families in our city. I would like to see this become a City function. Families are fleeing from the San Francisco. It keeps happening. People can't afford to live here, don't feel safe here, can't find childcare here. We need to do everything we can to keep this being a city where you can raise kids. It is such a tremendous loss to the diversity of our neighborhoods to be losing families.

So the scope of this department is huge, even though it's a small department. I intend to be a very outspoken person on the mayor's staff. We will be involved in the mayor's Communities of Opportunity. I would say that our department is very committed to community input. Every year, we are mandated to come up with a plan for the city's children.

One thing we've heard at Coleman over the years is how hard it is to access mental health services for children. I hope with Prop 63 funding, we can change that.

Mr. Medema: One of the reports I read said that you had yelled and screamed so long, that finally the Mayor put you in to do what you've been talking about. I'm amazed that the Mayor appointed you.

Ms. Brodkin: The Mayor said to me, "You've always been part of the solution, now we're inviting you to become part of the problem."

Mr. Medema: No one has been a better advocate for children for last 26 years. If there is one issue in terms of children's mental health that needs attention most, what would you say it is?

Ms. Brodkin: The question of access to services is overriding. Also we know how to do prevention, but it never seems to rise to the top of the priority list. We know we have to go where kids are and offer services quickly in non-stigmatizing ways. So I'm very committed to school-based mental health services.

Mr. Douglas: I can't imagine how any parent can keep track of 220 agencies. Don't we need a massive consolidation?

Ms. Brodkin: I'm glad you brought that up. DCYF has the most sophisticated tracking system in the city. I think we need to consolidate contacts for each agency, even though money comes through different departments.

The contracts we award are gruesome to draw up, and time consuming. If you want to get cost efficiencies, consolidate contracts and monitoring. Thank you for bringing that up.

Mr. Douglas: Do we need to get these 220 agencies together as well as consolidating contracts?

Ms. Brodkin: It's hard because of all the different things they do and different populations they serve. The Department has tried to push for consolidation. Agencies feel that what they do is so different. Proposing that they merge meets with lots of resistance.

Ms. Shaffer: One of our priorities this year is to respond to needs of kids in the school district, specifically: "Working with the school district to respond better to the needs of students and families dealing with mental illness, substance abuse, or significant emotional distress."

We've made some progress, but want to make more. We'll be doing our priorities again in December. What would you suggest?

Ms. Brodkin: That's an issue that's near and dear to my heart. I hope Prop 63 funding will go toward that, and Proposition H funding. I hope some of that money will go to counseling in the schools. Sophie Maxwell held a hearing on this issue yesterday. People got an earful. Fiona Ma is doing a resolution stressing the importance of mental health in the schools. I recommend that you insert yourself into these planning venues and let them know what you think. The Prop H planning process is just starting. That's a place to advocate.

Occasionally putting yourself on the agenda of the school board is not a bad idea.

And persistence matters. For example, advocates talked about the need for more social workers and nurses in the schools, and the Board heard it so many times, that when there was money left over last year, the Superintendent put the money into social workers and nurses.

Ms. Shaffer: If there is anything else you want to recommend, we're here and we'd like to help support you. Some of us are strong advocates for services for children.

Ms. Brodkin: I know, I've seen some of you.

I'm on the First Five Commission, which is another venue to think about, with regard to mental health issues.

At the First Five meeting tonight we heard about the effect of the money we put into mental health services in child care centers. I had been a skeptic but when I heard these stories tonight, they made me cry. I got to hear what actually could be done by working with the child care providers. I got to see the pictures that the children were drawing. These services are needed.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Behavioral Health Services (CBHS)
Mr. Batongbacal reported for Dr. Robert Cabaj who was in Sacramento: The most significant event in the past month was the passing of Proposition 63. We'll now be working on developing new services that are recovery-based, evidence-based, and consumer-guided. There are services needed that the system couldn't provide in the past. There will be a stakeholder process for the planning, which is a key part of Proposition 63, so we are creating a far-reaching process. We are waiting for guidelines from the state. The first six months of next year will be dedicated to the planning process. The money will be coming in by 2005/06 fiscal year.

Barbara Garcia wants the planning process to be very open. She wants all the meetings open with public input at all the meetings.

On a personal note, I want to make sure that consumers and family members are included in this process. There are a lot of stakeholders, such as the jails, police, and other partners who have had to deliver services to mental health clients in the past because of the inadequacy of our system.

In the meantime, there will be budget cuts because of the failure of Proposition J and K. The City budget will be reduced by $157 million, and specifically $15 million from the Department of Public Health. The Mayor has decided to spare substance abuse services from cuts because of the great need on the streets among homeless people.

Mental health services will be cut by $2.8 million, with a focus especially on indigent clients who are not seriously mentally ill. We still have to have a workgroup to figure out the definition of that population.

How does Proposition 63 relate to cuts in the basic budget? There is a stipulation in Proposition 63 that counties have to maintain the level of funding they had for mental health services in fiscal year 03/04. We still don't know how it will play out. The State Department of Mental Health is still working out how this is going to work.

The good news is that Proposition 63 presents an overwhelming infusion of funds. So even though there are cuts due to the failure of Prop J and K, those cuts will be a small nick compared to the new Proposition 63 funds.

With regard to integration, with Prop 63, we will have new resources that we can bring to bear to making integration work much better. We will be able to link services better. We can create mental health services within substance abuse centers and substance abuse services within mental health centers.

Mr. Douglas: There was a proposal to combine mental health clinics and primary care clinics in the same centers. What happened to that proposal?

Mr. Batongbacal: That proposal was made due to the need to make budget cuts. Most of the savings would have come from combining centers. But there was a massive ground swell of protest from advocates. So the Board of Supervisors decided not to support that proposal.

Mr. Douglas: It would seem to me that it would still be a good idea. We have a gay clinic out in an area of Lincoln Park which is not a gay mecca, and it could be located in the Castro which is a gay mecca.

Mr. Batongbacal: The proposals last year were developed in a moment of crisis. I think there will be ideas in the future for mental health and primary care to work closer together.

Supervisor Dufty: There was the notion of consolidating, for example, the Mission Mental Health Center. We were anticipating there were going to be primary care cuts, but we rejected some of those cuts. People were adamant about the Sunset Clinic not being closed.

About services for gays, there are gay kids all around the city, so it's good for them if the clinics are out in many neighborhoods. There was a gay youth center in Collingwood Community Center. It's now moved to Larkin, and the attendance has increased.

Supervisor Dufty: The Mayor has looked at Proposition 63, and we definitely want to have maintenance of effort. The Health Commission last night rejected some of the cuts. They said Shanti's breast cancer program, some integrated case management, and the compulsive gambling program should not be cut.

What's the program you were describing, Bob?

Mr. Douglas: The Team II clinic, which is at Monterey and Congo.

Supervisor Dufty: Yes, I helped negotiate a rent reduction for that facility. I had a meeting with a private philanthropist, regarding a $2.5 million donation to UCSF for mental health services to adolescents, and I connected him up with the Castro Mission Health Center. They are looking at going into existing places and bringing in private providers. Call me or Amanda and I can connect you with the professor at UCSF who is working on that.

Ms. Shaffer: I'm really interested in the process of communicating with families. You need to be very broad in how you communicate with families, so more of them can provide input on how they think services should be changed or augmented. It really should be accessible to everyone, and not just to particular clients that the agency deems might be appropriate.

Mr. Medema: The bulk of the cuts will be focused on the indigent population. Does that mean that outreach and case management for shelters will be cut.

Supervisor Dufty: The Health Commission accepted only half the cuts.

Mr. Medema: These cuts are happening now, but Prop 63 money won't come in till the middle of next year. What does Prop 63 make up for? Will it cover 100% of the cuts and restore those services?

Supervisor Dufty: The cuts are for an 18-month period.

Mr. Batongbacal: Prop 63 will bring in an estimated $50 million more in funds, and that can be used to match and draw down federal matching funds. So we will have about 1/3 more money for mental health services. So it could be decided in the planning process for Proposition 63 to cover those cuts and restore services.

Dr. Turner: You talked about process of involving stakeholders, but how does the final decision get made?

Mr. Batongbacal: A three-year plan will be developed then it has to be approved by the Board of Supervisors and approved by the state Oversight Commission and passed on to the State Department of Mental Health. So they will decide what is approved. At the

local level, the Board of Supervisors and the Mayor will probably have the final decision. But there will be a lot of input by the public. Aspects of the planing process have to include public comments.

Dr. Turner: Do we know when the first of the planning meetings will be?

Mr. Batongbacal: We are waiting for the state guidelines before starting those.

Ms. Knight: If the guidelines for funding have to keep in mind the fiscal year 03/04 funding, who's going to make sure that we stay with that, given all these cuts being made? If they see our county has dropped below 03/04 levels, won't the state take action?

Mr. Batongbacal: Yes, the state will be auditing that. We don't know how it will play out. We don't know how the state will enforce the counties to provide the same amount of funding. We don't know if they will they take out funding from Proposition 63 equivalent to what the locality has cut.

For a lot of counties, their 03/04 level of funding is higher than their current 04/05 funding.

Ms. Kellum-King: What about services for children who are severely mentally ill? How would that be determined? What would be the criteria and who would set it?

Mr. Batongbacal: A work group needs to be set up. This is not charted territory.

The line of thinking goes: San Francisco is unanimous in providing services to people who are indigent, and now that we're facing a budget crunch, we have to be realistic in who we can serve. So the focus on those most in need. But for milder conditions, if there is no payer, then it's hard to provide services.

Ms. Shaffer: You've been talking about people who have tried to get on all the different assistance programs, but you're saying that haven't been able to get on any kind of assistance?

Mr. Batongbacal: They are trying to figure out through the data system where the indigent are located. They figure 50% of those who indigent are not seriously mentally ill. A working group will have to decide who will not get treatment.

Mr. Medema: How many of those people with mild depression will become severely depressed and then need services? What about the importance of prevention?

mr. martin: Can I add on to that question: How many of those people are going to be treated in jail? I feel that reading the report is like driving a truck through a euphemism.

Mr. Batongbacal I think the process has to take risk factors into account. We need a predictive process. There are actually assessment tools to take into account complex factors around a person, but it is not a perfect system. And the reality is that we are going to be denying services to people.

Originally $23 million was going to be cut, but that was changed to $15 million.

Ms. Hewson: As a family member, I want to ask, Why did you use the term "chronically mentally ill."

Mr. Batongbacal: It's a term used to describe someone who has long-term issues, as opposed to someone with milder symptoms.

Ms. Hewson: I'm concerned that that term "chronic mentally ill" might become a self-fulfilling prophecy, rather than using the recovery-based system.

Mr. Batongbacal: With regard to the state audit of Community Behavioral Health Services, they said there needs to be a more active process on incorporating Mental Health Board input into the planning and budget process.

mr. martin: Becky and I represented the MHB in the audit. We found these deficiencies. It was a great, amiable process. We're going to have technical assistance from the State Department of Mental Health at our retreat in December. I think we are being accountable.

Dr. Turner: It's really a very positive thing. This person does training for the MHBs around the state on how we can be better advocates. We know our mission; he's going to help us go to the next level, which is very exciting.

Mr. Medema: About the outreach to homeless people by administrators, having worked at the Treatment Access Program, and being on the line when the mayor's office was shuttling those folks toward us, I want to ask: How real was this event vs. how much of a photo op was it? What does it mean to round up folks, but when they get to a center they find out the wait to get into programs like Baker-Healy is 60 days. How much of this is a service for the homeless and how much is this a service for the Mayor? And I actually like the Mayor.

Mr. Batongbacal: There is photo op aspect to it, but this event also enforces with city bureaucrats how important this issue is, and it identifies gaps in city services.

Mr. Medema: What does it say to the consumer to be brought into a center and find out that they can't get services?

Mr. Batongbacal: Yes, it is devastating. But we hope that future clients will be much better off because of this kind of event.

Dr. Turner: So there's a 60-day wait for services?

Mr. Medema: It depends on the program, but for dual diagnosis beds there is a long wait.

Mr. Batongbacal: One effect of this event was that, in the first version of the current budget cuts, $6 million taken from the budget for substance abuse services, but then as

people saw how much need there was for treatment, the Mayor said there would be no cuts from substance abuse services.

Ms. Brown: I'm just glad to see that agencies are starting to come together. This is a start.

mr. martin: Can you give an estimate of how much staff planning went into this, because it was a well-coordinated effort?

Mr. Batongbacal: There was a small planning group. Then 250 staff went to a 1.5-hour training, and then they spent 5 hours out in streets talking with people who are homeless.

mr. martin: How many people did they connect to services?

Mr. Batongbacal: There were 175 people who came into centers. But many more people were interviewed and surveyed.

mr. martin: It's especially ironic that this event happened five days after Episcopal Sanctuary closed their shelter displacing 200 people on less than 24-hours notice on a day of serious rains. It was a scheduled capital improvement closure. But I'm wondering how much of City resources in terms of staff time, was pulled out and not there to give these 200 people adequate notice to move. But, no I wouldn't say the outreach was a photo op.

Dr. Turner: I'm grappling with the impact of the whole discussion this evening. We're facing enormous budget cuts and yet with Prop 63 we have to maintain the effort for this money to come through. I don't understand how we reconcile that.

Mr. Batongbacal: There will be a clarification coming from the State on how the maintenance of effort is going to be carried out.

Mr. Douglas: On the budget cuts, are we going to cut both the City programs and the contract programs? And how many people are we going to lay off?

Mr. Batongbacal: The cut will be $2.8 million over 18 months to indigent people are not seriously mentally ill. So it is a mixture of civil services and contractors and private providers who will take the cuts. There will be a civil service cut of 6 FTEs. The location of the cuts depends on where the indigent clients are located.

Mr. Douglas: Did anybody think of charging a small fee to clients rather than cutting back?

Mr. Batongbacal: There is a uniform method to determine ability to pay. Some clients are actually paying small fees. So that's being looked at. We used to not collect fees if a client owes $100 or less per year. Recently we changed that to $50 or less per year.

Ms. Kellum-King: With regard to the homeless situation, we have an exodus of tenants from Public Housing because of the economic crisis in San Francisco. Some of the public

housing looks like ghost towns. Some of that housing could be used for people in recovery.

mr. martin: The Coalition on Homelessness identified 905 vacant units last year. They could be habitable for capital improvements of $5,000 each. But with alternative approaches like sweat equity, it could be done for a lot less.

Ms. Knight: Going back to the budget cuts, when you have a mental illness, it doesn't go away. A lot of these clients don't have family support. When you make changes in their lives, things can get worse for them. Then they will be in the serious category. I can't understand limiting services to a population such that you're going to make their condition worse.

Mr. Batongbacal: I agree with you 100%. It's very humane to provide services to people to help their health situation. And we're not talking about a lot of money. I would be much more depressed in these times, if it were not for Proposition 63. Proposition 63 will ultimately come to the rescue of many of our services.

The written Director's Report was distributed:

1. Mid-Year Budget Cuts. Because Propositions J (local sales tax increase) and K (local business tax) failed to pass, $97 million will be cut from the city budget over the next 18 months. The budget reduction plan prepared by the Mayor's Budget Office includes a total of $15.5 million in cuts to the Department of Public Health over the next 18 months. Substance abuse services were spared by the Mayor from $6 million in cutbacks, but about $2.8 million in General Fund reductions to mental health services will be incurred. The bulk of the mental health cuts will come from a proposal to limit services to indigent clients to only those with a serious mental illness—a savings of $2.0 million through June 2006. Mental health outreach and case management services to homeless shelters will also be reduced. The cuts are scheduled to be implemented on January 15, 2005.

2. Proposition 63 Passes. Proposition 63, the California Mental Health Services Act, was passed at the November ballot, winning 53.4% of the votes. By taxing incomes over $1 million at 1 percent, Proposition 63 will raise $800 million or more each year in state funds for mental health services. With increased federal matching funds, the amount of new money for care to people with mental illness is expected to exceed $1 billion per year. Proposition 63 revenues for services to children, youth, families, adults and older adults will be fully available and flowing into the counties in FY 2005-06. Before that time, county mental health departments will spend the first six months of 2005 working on a 3-year plan to be submitted to the state that details how the Proposition 63 allocation to the county will be used to expand mental health care for children and adults, using programs proven to be effective.

The proposition requires that stakeholders—consumers, families, providers, and other county departments—participate in the planning of how to use the new mental health funds. Counties are waiting for planning guidelines and timelines from the state Department of Mental Health, and will initiate local planning processes within the next couple of months.

For questions about Proposition 63 and CBHS plans, please call Edwin Batongbacal, CBHS Associate Director, at (415) 255-3446.

3. December 6 -7, ZiaLogic Visit. The plans for the roll-out of CBHS behavioral health integration at the program and service-delivery levels continue to advance with the assistance of ZiaLogic consultants, Chris Cline, M.D., and Ken Minkoff, M.D.

CBHS programs should take note of the following integration-related opportunities:

At their next quarterly consulting visit to San Francisco, ZiaLogic will conduct a big training on the Comprehensive, Continuous, Integrated System-of-Care Model for integration, directed exclusively to CBHS program directors, clinical and team supervisors, and senior and lead counselors/clinicians. This CCISC training will be held on Monday, December 6, 9:00 - 11:30 AM, at Fort Mason, Golden Gate Room. The training will introduce program management, and senior and supervisory staff of CBHS programs to the mission of improving their programs' Dual-Diagnosis Capability. To accommodate the greatest number of CBHS programs into this training, registration is limited to a maximum of 3-4 attendees from each CBHS program. CBHS programs can register their 3-4 participants with Junko Craft, junko.craft@sfdph.org or fax at (415) 252-3057.

On the morning of Tuesday, December 7, 9:00 - 11:30 AM, ZiaLogic will meet as a group with the initial batch of recruited "Change Agents," who are staff-members designated by their respective agencies to develop expertise on dual diagnosis integration in order to assist programs from within. This December 7 morning meeting will also be attended by CBHS Program Monitors and by the members of the CBHS Integration Implementation Workgroup. The purpose of this meeting is for ZiaLogic to brief the members of these 3 groups on their task of assisting individual CBHS programs towards Dual Diagnosis Capability. The location for this meeting is still being finalized. Each interested CBHS program/agency should submit the name of their designated "Change Agent" to Lucy Arellano, lucy.arellano@sfdph.org or phone # (415) 255-3687.

A videotape training on how CBHS programs can use the COMPASS Program-level self-assessment and planning tool (towards program Dual-Diagnosis Capability) is now available for borrowing from CBHS central administration. The videotape shows CATS Redwood Center, a CBHS substance abuse residential program, using the COMPASS tool under the guidance of Chris Cline. For more information on this training tape, please contact Bill McConnell, Director, CBHS Quality Management, bill.mcconnell@sfdph.org or phone # (415) 255-3435.

4. CBHS Completes DMH Compliance Audit. During the week of October 18 - 22, California Department of Mental Health conducted its annual on-site Compliance Audit of CBHS' San Francisco Mental Health Plan. At the audit exit conference, the DMH auditors were very complimentary of SF CBHS, noting the comprehensiveness and quality of the services. The DMH auditors reviewed 6 areas of the CBHS system in their Audit Protocol, audited 20 client charts, visited 4 program sites, and quizzed 7 CBHS program staff-members on their knowledge of CBHS policies & procedures. Outside of some areas of correction that were identified, the state auditors were overall very

impressed with CBHS staff, services, and facilities. A formal report will be forthcoming in the next two months. Thank you to Kevin McGirr and Jim Gilday for preparing CBHS for this audit, as well as to everyone in CBHS who helped out and participated.

5. Consumer Perception Survey. During the first two weeks of November, CBHS is conducting a Consumer Perception Survey of its mental health clients, as required by California Department of Mental Health. Mental health programs will be distributing these surveys to their non-residential and non-crisis clients. Clients have the option of either dropping the surveys in the mail themselves (in a postage-pre-paid envelope) or giving it back to the program. A steady stream of returned, completed surveys are now being processed by CBHS staff.

3.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke: I want to thank Kate, Idell, Bridgett, and Bob for their participation in the Eleventh Police Crisis Intervention Project. Kate and Idell were role players. Bridgett was a panelist. Bob and Joel, who is in the audience here tonight, were table hosts.

We have a lot of experts come to do presentations, but the panels and the interactions with consumers and family members, along with the role playing, get the top ratings by the officers.

I appreciate Becky and Chance for participating in the state audit of CBHS. It will give the Board a stronger opportunity to participate more in planning and development of services.

Dr. Turner: Helynna's right, it is a good thing that the auditors saw that we need to be more a part of the planning. Chance and I felt it was a great time to get more involved.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee
Dr. Turner: I want to ask if anyone has comments on future actions related to the presentation we had tonight from Margaret Brodkin.

Mr. Medema: One of the things she suggested is at least an annual visit to the School Board meeting to make our voice heard. It might be nice to see that incorporated more formally into the Board. And to make it separate and in addition to individual members who go to the Board for specific issues at different times during the year.

Dr. Turner: That sounds like a good idea.

Ms. Kellum-King: I'll volunteer to be one of those people who go to the School Board meetings.

Bridgett: I went to the Treatment on Demand Council meeting last week.

5.0 NEW BUSINESS

Ms. Knight: I want to mention the NAMI Walk taking place next May 21st. This is the first walk for San Francisco. It's very important to get this walk going and make it successful. We will be giving out packets at Board meetings to encourage people to get their own teams together.

mr. martin: I would like to propose that we ask Richard Heasley or Seth Katzman from Conard House, and/or Jackie Jenks from Central City Hospitality House, how contractual re-alignment of DPH programs to DHS programs is creating losses of services to homeless mentally ill. There's this huge contractual change of funds, and there is not the provision to provide low threshold mental health services.

Ms. Kellum-King: I would like the Board to pass a resolution to be in support of the NAMI walk.

Mr. Douglas: I would like to hear a presentation from the Public Guardians. The statewide CALMHB organization is having a big investigation of Public Guardian offices.

6.0 PUBLIC COMMENTS
No comments.

7.0 ADJOURNMENT
There being no further business, the meeting was adjourned at 8:35 p.m.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

Gavin Newsom
Mayor

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

Minutes

RETREAT NOTES
Mental Health Board
Saturday, December 4, 2004
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Rebecca Turner, Ph.D. (Chair); Bridgett Brown; Bob Douglas, J.D.; Supervisor Bevan Dufty; LaVaughn Kellum-King; Carol Knight, M.A.; Joel Luebkeman; Michael Medema; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Idell Wilson.

BOARD MEMBERS ON LEAVE: chance martin; Sandy Yuen.

BOARD MEMBERS ABSENT: Augusta Del Zotto, Ph.D., Ted Stinson.

PRESENTERS: Ed Diksa, Director of Training, California Institute of Mental Health

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 9:15 a.m. by Rebecca Turner, Chair.

Dr. Turner: Welcome to our 2004 Annual Retreat! Thank you all for being here. It's never easy to give up a Saturday.

To get to know each other better, we're going to start today by going around and each sharing why we wanted to be on the Mental Health Board, what brought you here, and what has been your most compelling experience.

I'll begin. I started twenty six years ago providing services. I started working with emergencies on the night shift. I would be called by emergency rooms or the jails. I would interview people in crisis, and find out if they needed to have mental health services instead of being in the jails or instead of being in the emergency room. I was in that job for two years. It was very moving to me to see that world from that perspective. It was very good experience. There was no one else awake in the middle of the night to give me advice. It was an amazing education.

I felt these experiences were unbelievably moving. Hearing people's stories, seeing that in crisis situations there were things you could do. The sad part was not knowing the follow up for those people I worked with.

Then I spent a long period of time doing clinical research. Then in 1994, I got an opportunity to work at a crisis center. I thought I had seen everything. One night when we were about to close the Crisis Center, there was suddenly a loud noise outside and the door opened. A guy walked in and fell on the floor. He said, "I've just been stabbed, you stupid bitch, why are you just looking at me?" We called 911. A few people gathered around. There was a homeless man outside who was paranoid and felt he was being invaded by this guy.

I realized then how incredibly difficult it was for some people to get services, and the extent to which you had to be in deep, deep trouble before you got help. A few years later when I had more time, I decided I wanted to do something in the community. I called some boards which didn't have openings. Then someone told me about the MHB, and I said, "Yes, yes. I really want to do that."

Ms. Brown: How I came to be at the MHB was that Roy Crew, Director of the Oasis Center, said I should go for the Consumer Seat on the MHB. He's been a mentor to me, along with Carol Patterson. I had been on different boards in the community, but this is my first appointed board. One of the reasons I joined was because I wanted to see more consumers in jobs in the mental health field. I guess it's happened a little bit, but not to the extent I was hoping for. This issue is close to my heart.

Ms. Walker: Bridgett, I heard you speak before the Board of Supervisors one day, and you gave a short little talk, right to the point, You did it in such a compelling and ladylike way. I was proud to be on the Board with you.

I worked as a Patient's Rights advocate. This was before the advent of the HMOs. Mental hospitals were making money from patients and wanted them. My job was to help people get out of the hospital, people who were there against their will. For a day or two, you get so intimate with people and what their troubles were and then they're gone.

I don't know what craziness is, but I went there. It wouldn't take a professional to know that I was out of my head. The treatment I got before I went crazy didn't help me. From my point of view when I started working with hospitals, I thought all those doctors were crazier than we were, but I found that was not so.

What draws me to the MHB, is that as a society we force treatment on people that they don't need. People like me are apt to say that all treatment is bad. I want to work on this Board with people who see where the treatment is good and people like me who can see where the treatment can hurt.

Mr. Douglas: I've been accused of many things, but I've never been accused of being bashful. My first experience with mental health was when I was going to law school, and needed money. I got a part-time job representing people on 5150 hearings. While I'm appointed as a family member, I'm also a consumer in a very thin disguise. I have

an atypical depression, which means I'm either okay or in very bad shape. I also don't respond to medication, or the side effects are challenging, such as dry mouth and sexual side effects.

I got mugged last night and got hit on the head. I'm also upset because the MHB, as far as I can tell, had absolutely no input on the current cuts on mental health.

Ms. Knight: I originally didn't want to be on the MHB, I was at a conference minding my own business and down the aisle comes Helynna with a stack of yellow flyers about the MHB. My supervisor introduced us. Helynna gave me a flyer. She didn't know that my son has a mental illness. It was something I kept to myself. I took a flyer and we traded numbers. A few days later she called me and it took off from there. She encouraged me to be on the Board. I never would have joined the Board on my own.

The first meeting night, it was amazing. I met so many incredible people and they were so welcoming, like Kate and Bridgett. It's been really rewarding being able to share my experiences as a family member. That was a new experience for me. Then my feelings changed to: Gee, I'm the proud parent of a son with mental illness.

I've become a die-hard advocate which I didn't know I had in me. Like Bob was saying about the budge cuts, that's really hurting me. I want to be able to do something to help family members through these cuts. I want to be there for other family members. Thank you, to everybody on the Board.

I've been given a position as a Social Worker in San Joaquin County.

Ms. Kellum-King: I wanted to say to Bob, you're a real trouper because you showed up today. What brought me to the Board was my son, Noah. I was taking a class at Kaiser to lean how to better parent him, and to get some knowledge about the issue. In taking the class, I met Carol, and we had a lot of similarities. I said to her, "Why don't we take the training so we can teach this class for others."

So we went to Sonoma and took the training. The first night of our first class, it was rainy and stormy. We thought no one would come, but by the time we were ready to start the class, the room was full. In teaching the class, I learned so] much about my son. My mom who raised five children also had a mental illness, I now really appreciate her to the utmost. She made sure we did our homework; our clothes were always clean. She would have her crises and we'd have to help out, like doing the shopping. I asked my dad, who didn't live with us, to put her in the hospital. But I loved her, and she cried and then I would take her out.

Gavin Newsom was going to appoint me last year, but he was running for Mayor and didn't get to it in time. So finally Michela Alioto-Pier appointed me.

I know what can happen. I know what my mom did for us. Thank you for letting me be here with you.

Mr. Luebkeman: I liked what LaVaughn said. I'm here because of my sister, Linda. I got to know Helynna when I was running for the Democratic County Central

Committee four years ago and I was sharing with her some of what happened to my sister. I never realized how a person can change. How you can lose the person you know. My sister has schizophrenia. She was a person who was always happy and always positive, and now we've lost the person we knew.

Helynna asked me if I wanted to be on the Mental Health Board. It was a way of learning about mental illness. I didn't know how to deal with a lot of the things that were facing me. With my sister, we were very fortunate that we got a great doctor at Kaiser. The first thing she said was that she wanted the whole family come in. She said the difference for your sister will be made by you, her family, and how you support her. Normally, you think about turning this over to professionals. But I've seen the difference it makes for my sister to have a family supporting her. And in San Francisco, we are the family for people who don't have family support of their own, or families who can't deal with them. It's really important to have the support of government and the citizens of San Francisco as family.

Mr. Medema: Long before the big earrings and tattoos that I've got now, I used to work downtown in a suit and tie as a finance administrator. For a long time I enjoyed what I was doing, and certainly enjoyed the money. Then I decided I wanted to make a complete change and work for something that was giving back. So I walked away from Corporate America. I started on the graveyard shift at Walden House from 11 p.m. to 7 a.m. When I started working there, they told me nothing ever happened at night. Four nights later, someone came in and told me God was telling him to kill himself. I knew then that this work was going to change my life. I have had people cut their wrists in front of me and take pills in front of me.

I have friends and family members who want to know how I do this work every day all day long. When I was appointed to the MHB, they said, "Don't you do enough of that?" For me there's not enough of that. There are too many people in our society who get pushed to the side, get marginalized, and don't have enough people to fight for them.

I've known Supervisor Bevan Dufty since long before he was working with Susan Leal. I had an appointment to go talk to Bevan about some issues, and when I got there, Bevan was having a champagne reception at that same time. He kept getting up from our meeting to go shake hands with people and talk issues. And then he said, "I think I know what you need to do. I have a seat I need to fill on the MHB." Which is fabulous, because it did me a chance to take my problems and put them into direct action. I fill a Public Interest Seat and I am easily a family member and a consumer and on some days a professional. I just feel so passionately that people should not have to be denied the basic services that anybody should get under just plain basic human rights, for lack of money, or lack of mental capacity, or lack of intelligence, or lack of anything So I'm a fighter and an advocate. The MHB is a really good spot to hopefully affect change.

Ms. Shaffer: A year ago, I had to wheel myself in here, because of knee surgery. It wasn't a problem going through the health care system for my knee. What I've learned is that mental health is a health problem. When I first met Helynna, I was at a parents group and our family had to make a very difficult decision about placing our adolescent family member in residential care. The assessment was poor to say the least. The Kaiser system said there was no hope for my son, who at the time was 12.

I've now been told by the county system that the recommendation is now to put him into residential program, and was told there is no hope. We've been on the phone calling facilities, looking for an appropriate place so our family member can graduate from high school, and get some appropirate psychiatric help. I'm here to make hope the focus. No one has a right to say there is no hope.

The doctors last year did not tell me to cut off my knee. There is nothing different between physical health and mental health. We're not very sophisticated in San Francisco especially when it comes to child psychiatric needs and as they transition.

I'm not always the most sophisticated speaker, I'm an exhausted family member, I hope I don't end up as a consumer. I see a lack of sophistication in mental health services for youth, but I'm not giving up and I'm not giving up hope on our family member

Dr. Moses: I got involved with mental health services when I left the school of Public Health in 1978. I started an internship in a substance abuse program in the Western Addition. I was really sad to see how the African American males were suffering from the alcohol syndrome. When I finished my internship, I was hired as executive director, and was there for 8 years. The Western Addition used to be mostly African American in those days. Things have really changed.

So when I left that place, I worked at the jail in the psych unit and saw a lot of the same people I had seen at the clinic. I love to advocate for people who can't speak for themselves.

Tom Ammiano appointed me to this Board. I was on the Board for two terms, then was off for a year. Helynna said, "I want you back. And who can say no to Helynna?"

Mary Sue Planck, our former executive director, worked so hard, and she died unexpectedly in 1999. We were able to find Helynna as a replacement. I love to support her because she's such a very hard worker. I like meeting all these nice people. I think I'm the oldest one here next to Kate. It's nice to be around people who care and who want to advocate for people who can't speak for themselves.

Dr. Turner: I appreciate everyone being willing to share their stories. I want to mention that some of the agenda descriptions are attributable to Kate.

Now I want to introduce Ed Diksa. We had an audit recently of Community Behavioral Health Services by the State Department of Mental Health. Chance Martin and I talked with the auditors about the MHB, and it was a great experience. The auditors talked about how we can maximize our impact. And they recommended us getting Ed Diksa from the State. This is a really big year with Proposition 63.

Ed is Director of Training for CIMH. He's been in that role for six years. He was an MHB member in Sonoma County for six years. He was also President of the California Association of Local Mental Health Boards/Commissions.

One of the coolest things about him is that he lives in Cool, California.

Dr. Diksa: To orient you to my biases, there's a scene in the movie Outrageous, a late 70's Canadian film that I want to mention. Part of it takes place in inpatient unit in a hospital. I saw it 25 years ago. A woman was in her room screaming. She had her hands up. Something was attacking her. The camera pans to a staff member in the door way with his chart out charting her behaviors. The protagonist rushes in and gets down on the floor with her, and says, "I can't see what you see, but I if put my hands here between you and whatever it is, maybe we can get it away from you.

I think it's important to meet people's needs instead of focusing on their pathology.

When I was working in a center in Marin County, one guy lost it. I was there by myself. I was scared and was starting to hyperventilate. He saw that and he came out of his crisis and said, "Just be with me. That's all I need." I said, "Okay, I think I can do that."

Another guy I worked with was described as delusional in his chart in the hospital, and that he talked about being poisoned. We never saw any delusions while he was in our unit for a year. I asked him about it and he said, "Did you ever eat the food there?"

In our system we look for the pathology, and we never check to see if it's really pathology. It's so important to see what's real.

When I was appointed to the Mental Health Board in Sonoma County, my lady friend was working at a treatment facility. She often came home crying because of the way people were being treated. She finally quit, and then they called her to come in on a per diem basis. The last day she was scheduled to work there, her body broke out and she was covered in hives because she was so stressed. I got on the MHB to make things better.

Through CIMH, I work with family members a lot. A mother told me that when her son was 21, the therapist pulled her aside and said, "Your son has schizophrenia. Get used to it. His life is over."

That's not ancient history. When you look at the longitudinal studies, people with schizophrenia do get better over time.

One part of my job is to teach staff how to write service plans with recovery as part of the plan.

I ask them if they talk with their clients about what their lives would be like if they didn't need mental health services any more. We need to give people services and then we need to help them get out of the system. No one wants to be a mental health client for all of their lives.

You as MHB represent the electorate. Two things I'm going to talk about today are first your roles and responsibilities as the Mental Health Board, and then about Proposition 63.

In a nutshell: You are supposed to understand the mental health services provided in your county and the needs of your community. You work with the Board of Supervisors and they system to meet needs of the community.

There are populations in the community like the MediCal and indigent populations that we focus on in the public mental health system.

But then there are all kinds of mental health needs that don't get covered. People who are employed but have no health insurance, for instance. A huge amount of MHB time is focused on the MediCal and indigent population, but the legislation says, "the mental health needs of the community." That's why you need to have a good relationship with the Board of Supervisors, and not just the mental health system.

"The reputation of the San Francisco Mental Health Board is that you're one of the best in the state in terms of knowledge and awareness and the things you do."

I'm going to go over MHB duties in reverse order:

#8 Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a Mental Health Board.

The Board of Supervisors can ask you to do anything they want, preferably in relation to mental health. For example, if the Grand Jury came out with stinging report on services, it might be requested that you hold public hearings.

#7 Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.

The California Mental Health Planning Council is a statewide body, parallel to local MHBs. Its members are appointed by the Director of the State Department of Mental Health. They include a wide range of stakeholders, about 40 people. They advise the State Department of Mental Health in much the same way you guys advise your local systems. They wrote the Master Plan for the State. It's on the website of the State Department of Mental Health. It's really worth reading. It's about 12 chapters. It's re-written about every five years. With Prop 63, they'll probably be adding another chapter.

You're supposed to get the systems performance data. you're supposed to read it and write a report to the planning council. It can be just as short as, "We got the outcome data and have looked at it." There is a committee working up a template to give to local MHBs in terms of the report format.

There will be a local training of MHBs probably in February to talk about Proposition 63. You have a really important role in Prop 63.

#6 Review and make recommendations on applicants for the appointment of a local director of mental health services. The Board shall be included in the selection process prior to the vote of the governing body.

#5 Submit an annual report to the governing body on the needs and performance of the county's mental health system.

I suggest that it only be two or three pages so the Supervisors will read it. Just give them the basics.

#4 Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

This is Class A bureaucratese. What does it mean? Every county interprets it differently. This is the only place that the word "approve" is in the law. This will become very important with Prop 63. This being San Francisco, the electorate is not shy about speaking up. But you need to look at what it means to have citizen involvement at all stages. Some county supervisors don't let the MHBs be part of the process.

Dr. Moses: Sometimes it seems that the Department of Public Health doesn't really recognize the MHB. Under integration they are trying to phase us out. The time they seem to need us is when there are budget cuts.

Dr. Diksa: Yes, kind of that attitude. Your own MHB handbook phrases it nicely, "Working by influence rather than authority." How do you politely let people know that you represent the electorate, too. It's important to have a strong relationship with the Board of Supervisors so if DPH shuts you out, you have other access.

In Contra Costa County, the MHB has a monthly public access show on mental health.

Ms. Brooke: There is a problem with a couple of Supervisors not meeting with MHB members. Dr. Diksa: Do the aids meet with them? Ms. Brooke: Yes. Dr. Diksa: I recommend meeting with your Supervisor or their aid on a quarterly basis for 5-10 minutes. It helps if you're not always complaining, but instead sometimes you're just there to thank them for what they've done.

Dr. Turner: I think we have a real opportunity under Prop 63. I don't know who wrote the MHB into the initiative, but I love them for it. But we have to make sure people know what our role is.

Dr. Moses: Do you have the money in your budget to do a training for the MHB and the Health Department about the role of the MHB? I would appreciate it if the Director of Public Health could hear directly from you.

Dr. Diksa: I'd be happy to come back and meet with you.

#2 Review any county agreements entered into pursuant to Section 5650.

This agreement used to change significantly every year. Now it's boilerplate. It varies little from county to county and year to year.

#1 Review and evaluate the community's mental health needs, services, facilities, and special problems.

I recommend meeting with the Supervisors often enough that they know you and trust you. Nine out of ten people talking to a Supervisor have complaints. You stand out if you are talking to them about successes. Once they know you, then when an issue comes up, they'll turn to you if they trust you. They will listen to you if you have developed that relationship.

When a Supervisor is running for re-election, you can volunteer for their campaign. They appreciate that.

Ms. Brooke: If you develop a good relationship, then you become a resource for them on mental health issues.

Mr. Medema: The point about meeting with the aids is really important. Those are the people who control the calendar. If you know them, when you're not able to reach the Supervisor in person, they can get the Supervisor's ear.

Mr. Luebkeman: And sometimes they become the Supervisor.

Dr. Diksa: The aid to my Supervisor in Sonoma county was a much better advocate with the Supervisor than I would have been. So my time with her was very valuable.

How is your relationship with Director? Ask him what he is planning for the future. A lot of Boards get told about the budget document at the last minute. Ask to be included in budget planning meetings from the beginning.

It's important for Boards to make the transition from a listening culture to a doing culture. That's a hard transition.

It's important to get to know each other. The ice breaker this morning, telling the stories about why you're involved, helps us trust each other.

Dr. Turner: I think that transition is more important than ever, to move from a listening culture to doing culture. Not just setting goals, but making sure we accomplish the goals.

Dr. Diksa: Your relationship with Board of Supervisors can be really helpful. Every year we'd have one family member and one direct consumer speak to the Board of Supervisors in public comment to say thank you. Most people complain. If you have someone say, "Thank you, something's working," it shocks them, and they appreciate it.

The people you should have talking to you at Board meetings and making presentations, are the people who raise an issue that gives you homework to do. You need to figure out who's going to be presenting and why and what does it give you to do.

We have an outline of the things we're looking for in each presentation, including the challenges the program is struggling with, not just all the successes. (Handout)

Ms. Brooke: We send a letter to speakers ahead of time, but we include most of the things in your outline form in our letters, and the speakers do talk about the challenges.

Dr. Diksa: I suggest you put 10-15 minutes on the agenda for discussion after each presentation.

Mr. Medema: I suggest we have this sheet at the Board meetings for members to use as a guide for us to ask questions. We're not really doing committees.

Dr. Turner: We used to have committees but they didn't work out well. We're going to talk this afternoon about whether we want to work in task-oriented teams or re-institute committees.

Dr. Diksa: You have such a broad scope of services to cover, so most of the real work needs to be done in committees. I suggest the committee chair writes a one-paragraph report to the chair of the Board. You could have committees by the three main groups of clients, children, adults, and elders.

Dr. Moses: From your experience, how do you handle mental health board staff? How do you handle overwork and underpay?

Dr. Diksa: I think if you do a lot of the work in committees, in some ways it's easier on staff. If you have a routine, it becomes more efficient than rather trying to scatter everything.

Mr. Luebkeman: Does it make sense to have a focus for the committee, like a project? What are they going to produce? So the purpose of each meeting is to make progress on that project. If we're advisory and get together each month and just talk, what's the purpose of that?

Dr. Diksa: This afternoon we're going to set goals. We can have a committee for each of those goals. That might be more apt to get me to come out at night.

Mr. Medema: If you break it down as you were saying as Children, Adults, Elders, then we can address goals as they reflect on each of the communities.

Mr. Luebkeman: I think there needs to be a focus for each of the committees.

Mr. Diksa: It's important to show the Board of Supervisors the rationale for your recommendations.

Ms. Kellum-King: Maybe instead of having a lot of little committees, maybe we could have the Executive Committee and three others.

Mr. Medema: If those committees produce a report every month, it could be used by the Board of Supervisors, and for the Annual Report.

Dr. Diksa: You can have people from outside the Board serve on your committees.

Dr. Turner: With Prop 63, we will find a lot of interest from other people.

Dr. Diksa: It's important to also have a relationship with the Health Commission to help develop your relationship with DPH. You can also go out to talk with different community organizations, go out into the faith community, and connect with your natural allies in the community.

It's good to be thinking now about who do want to invite to the public hearing to make sure that they are there. Make direct personal invitations as well as sending out a general notice.

TRAINING ON IMPLEMENTING PROPOSITION 63
Dr. Diksa: Prop 63 is meant to change the mental health system and move it into the Wellness and Recovery mode. This will not be business as usual.

The Proposition is looking at real world outcomes, not just the reduction of symptoms. We've focused so much in the past on stability that we don't look at where stability turns into stagnation.

Mr. Luebkeman: What's the distribution process?

Dr. Diksa: The State will come up with a formula. Part of it will be based on the need in the county. And it will look at past funding. In San Francisco, you have in the past gotten the largest per capita amount of money in the state. It's been an issue forever that not all counties are funded equally. There has been legislation to address it.

The State is saying that the money is not just for MediCal folks, but for everyone at 200% of poverty or below.

Ms. Knight: I'm concerned about administrators making all the decisions and not seeing what the clients really need.

Dr. Diksa: We can have people from the State Department of Mental Health talk with them about what the law requires. I think there are mental health departments around the sate who play it close to the vest. If everything is working well that can be okay for them. But if there are problems then they have no allies because they've left people out of the process.

You need to hold the system accountable to consumer involvement and the recovery perspective.

We need a system with a planned exit. The top three reasons people leave the system are: 1) we don't know 2) they move, and 3) they die. But under Prop 63, we want to see that people are being integrated back into the community.

Housing is a big issue and Prop 63 funds can be used for housing.

We want people to be doing better than "stable." Stability by itself is not recovery-oriented. We want people to have more than in their lives than just stability.

Mr. Douglas: Our housing in San Francisco is so expensive. But we do have a good team of consultants working with our system.

This does get complicated. We have City employees but they also want to have a good job. Then we have nonprofit agencies that want to help people, but they also want to build their empires. Our job is to focus on helping people, period. It's very hard to me to separate the desire to help people from the need to make a living, but that's our job to separate out what's best for clients, even if we use a lot of peer counselors, even if we'd have to lay off social workers.

Mr. Diksa: What makes a good system?

1. Consumers feel safe and glad to attend.
2. Staff are eager to go to work.
3. Funders are proud to support it.

Mr. Luebkeman: When the Mental Health Rehabilitation Facility (MHRF) was threatened to be closed, we had testimony from SEIU which is politically powerful. And we had to ask, How much of this is about saving their jobs and how much of it is about what the clients really need?

Ms. Knight: A lot of people have been laid off in former cuts, now they are going to hire new staff under Prop 63, and I worry that they won't be the same kind of advocates as many of the former staff who had been in the system for 20 some years.

Dr. Turner: I think one job we're going to have this year is that we're going to have to deal with housing vs. mental health funding. I think it's going to be a challenge for us and we're going to have to do our homework on this.

Mr. Diksa: There will be a State Oversight Committee, 12 of whom are appointed by the Governor.

Dr. Turner: Barbara Garcia will be spearheading the Prop 63 planning process in San Francisco.

Mr. Diksa: If I were you I'd argue for an MHB representative on the Steering Committee for the Prop 63 planning process.

Ms. Knight: There's already a lot of discussion going on within DPH. We need to be included in the planning from the beginning.

Dr. Diksa: You are supposed to be involved at all stages of the planning process.

Ms. Brown: It's all good that they say it's going to be open to the public, and that we can give input, but then the result can be a whole different thing.

Dr. Diksa: Once the plan is developed, any significant critiques must be addressed.

Distribution of funds is to follow these guidelines:
- 10% to education and training (05-06 to 07-08)
- 10% capital facilities and technology (05-06 to 07-08)
- 20% (or more) prevention/early intervention (no time limit)
- 5% innovative programs
- 55% for Children's System of Care, Adult System of Care, Older Adult System of Care development.

Dr. Moses: Is there going to be a watchdog over the expenditures of funds?

Dr. Diksa: You can help do that. There will be a state watchdog group, but they are all volunteers. If we don't do this right, it will screw mental health.

The role of the MHB is to hold a "public hearing on the draft plan," and include any substantive written recommendations. Then to summarize and analyze the recommended revisions. Then to review the adopted plan and make more recommendations for revisions.

LUNCH BREAK

Dr. Turner: As we move into planning this afternoon, we need to get clear about our goals and objectives. Our role in Prop 63 is enormous. I think our overarching goal for the year 2005 has to be to be involved in the planning and implementation of Prop 63. But what does that mean that we would actually do?

So now I would like to hear from everyone what your priorities are with regard to Prop 63. And then let's look at how we will implement our priorities. Will it be through committees? Will it be through specific work groups or teams? Do we need to be out in the community hearing from people? Do we need a committee to plan the hearing that we're going to be doing?

Ms. Brown: We've always been fighting for Mobile Crisis to be open 24/7. And to make sure we have one or more additional 24/7 drop-in centers.

Mr. Douglas: There was a White House conference on mental health, and what they said was that we need more groups and we need more peer involvement as care providers. Peers can then become professionals. I think we need to reach into the Department of Public Health and make sure that we have a seat at the table for planning. I think we can be a catalyst for real consumer involvement.

Ms. Walker: I want to explain what I meant by that title on the agenda "Bee in your bonnet." In our monthly meeting, we get excellent speakers, but I don't think we do enough as follow up. I think the 24/7 drop-in center should be on the agenda. But I think as a group, we didn't do anything about it. I think we should discuss what we would like to do and how we will do it, instead of just saying something is a good idea.

We have such talent here. We have enormous talent. I feel we don't use it. I think instead of planning this afternoon what we're going to do the whole year, I'd like to hear where each person wants to put their energy. Carol and Dorothy want to put their energy into children. I want to figure out where the City could save money by using a different system. For instance if we had a 24-hour drop-in center, where would that save money? And I'd love it if other people had ideas of how to implement that.

I think we need to get our facts and figures together and then we can present them to the Commission on Prop 63.

Mr. Medema: I think this Board does need committees in some form. I think how we set those up and what we do with them remains to be seen. I think in the Board meetings we have, it's extremely difficult to accomplish work when we have speakers and the public. We need to have a working space. We need to come forward with resolutions saying this is where we're at and what our recommendations are. I think it's extremely important that we be able to do that this year. We are at a time, where this Board has the ability to involve itself and exert its power.

Even though we are only an advisory Board we do have the power to accomplish things and make things happen. I'm not for adding more meetings to my life, but I'll add two or three more meetings to my life if it makes a difference. Mental health is my passion. I was asking at lunch if we would have more power if we were meeting in City Hall. It would make it easier for Supervisors to come to our meetings if we were meeting in City Hall.

The number one thing for me is making certain that Barbara Garcia hears from us immediately that we want two or three seats on the Prop 63 planning steering committee. We will look like fools if we are not involved in the planning process.

Ms. Kellum-King: In relation to the comment Bob made about peers as care providers, I would want services going to the clients who really need them, and their peers could appeal to them more. If your peers are speaking to you, they get that you are ready now to go to work.

I appreciate the speakers, but I would suggest that we have one speaker per meeting, or every three meetings. And then we would have the time to have the dialogue.

Ms. Knight: How binding are the percentages that are listed in Proposition 63? Is it totally binding?

Mr. Diksa: The way it's written it has to be those percentages, but there is wiggle room in terms of what you call something.

Ms. Knight: Since I've been on the Board, we've had committees, but they haven't worked. But each of use has our own strengths. If some of us would come to committee meetings that would be great. But perhaps we need to get out in the community more to talk to people about Prop 63 and mental illness. I would like each one of us to focus on what we're strong on. Let's work where our strengths and passions are.

Ms. Kellum-King: With committees we have to be careful because we don't want a bunch of angry people working on our committees with us as non-Board members. We want passionate people, but I think we need to educate ourselves first about Prop 63. We can even question each other to see how accurate we are.

Dr. Turner: In forming these committees, we have to think carefully about how people get on these committees and make sure people are going in the same direction.

Mr. Luebkeman: Perhaps we could end some of our meetings early so the committees could meet and hand out assignments. I think we have to be careful in selecting non-Board people for committees, so we don't get people who just want to hear themselves talk for an hour. The purpose of the committees is to produce something. People can take on assignments.

Mr. Douglas: It might work to have our committee meetings before the Board meetings like at 5:30. I would feel fresher then, instead of after the Board meetings.

Mr. Luebkeman: We know a lot of jobs are moving out of the City and we need to give people time to get back into the city from their work.

Ms. Shaffer: How do we define what's education and training? If we're going to be adding more services and changing things then the service plans are going to change, too. We need to be planning about that. This discussion has given me a lot of questions.

Mr. Luebkeman: I would argue that the funding be focused on services rather than housing. There are still a lot of sources of funding for housing, and not enough for services. I think we need to provide the services.

Ms. Walker: This is why I think we need to talk to each other. For instance you and I disagree, and we need to find the areas where we agree with each other so we can advocate effectively.

Mr. Medema: It seems to me there are two priorities for the Board:
1) Where is the money actually going to go? What are the services going to be? The Board could take a position on where we want the money to be spent once it starts coming in. 2) The planning, processing, implementation. One of those is already starting and we're not a part of it yet.

Dr. Turner: Bob Cabaj is not organizing any more informal meetings. The Prop 63 campaign steering committee is still meeting. Barbara Garcia is developing the stakeholder meetings. And those meetings then will always be open to the public.

Mr. Medema: And that process needs to be set up by May and we need to hold a hearing in June. It's hard to think that we're going to walk of this meeting today without a plan to start the process, we'll be losing time on something that is extremely important. I don't want to start talking in February about a hearing that we need to hold in June which will be open to the masses.

I think we want to be involved in the planning process, and second take an active role in recommending and advising where we want the money to be spent.

Ms. Walker: I would hope that each of us could bring to our January MHB meeting, what we would like to do.

Dr. Turner: We probably should set up a Prop 63 committee right after this retreat and from there spin off what other committees or groups are needed, so we have a structure for beginning to speak with each other.

Someone I think we could include is Belinda Lyons, the Executive Director of the MHA. Their organization was instrumental in getting Prop 63 passed. They got a 74% yes vote in San Francisco.

We could have a temporary committee called Prop 63 so we can develop what needs to happen structurally from there.

Mr. Douglas: We might meet on Wednesday, December 8, which would have been our regular Board meeting night.

Ms. Knight: Shouldn't we have someone from the mental health system come to that meeting, since they are going to have the say on the process. They should be at the table with us.

Dr. Turner: Perhaps Barbara Garcia and Belinda Lyons.

Ms. Walker: As Michael said, perhaps the first meeting should be among us.

Ms. Wilson: We should emphasize that this is only a strategy meeting, then we won't get people there with all their projects.

Mr. Medema: Ed, we asked you to stick around to consult with us. Now that you've heard us, what do you think?

Mr. Diksa: I think it makes an infinite amount of sense to get a plan of how you want to participate in designing the process, and then connect with the system. Think of the stakeholders who should be involved. Think as broadly as possible. In one county the best person to give information about the kids and teens was the guy who ran the video parlor, because he was seeing the kids in their natural element.

Proposition 63 is supposed to help you massively change the way services are delivered. I think people who are already receiving services in your system, the longer they have been in, they are somewhat institutionalized and their identity becomes being a mental patient. It's important to focus as well on first-break clients. How do you set up a system to help people get out of the system as soon as possible?

There is the phrase that discharge planning should begin in the assessment. But we need to make that happen. Some people will need services for the rest of their lives. But

there are people who get trapped in the system who wouldn't be there if we had a different attitude about hope, about recovery.

Information is easier to learn than skills which are easier to learn than changing attitudes. One of your roles as the Board is to focus on attitude change.

Also it's important to look at trauma. About 35% of our clients are diagnosable with PTSD. In subgroups of our clients, PTSD can be near 100%.

I hear the phrase that people are so sick they don't know they need our services. If someone has a negative experience with services, they associate that with the trauma and won't want to come back.

Ms. Shaffer: Do you have some of the key phrases with regard to attitude change?

Dr. Diksa: Some of the words people brought up here today were: Hope. Having a future.

When hiring new staff, I like to ask: Of your past clients who had goals, what was the goal that you disagreed with that you still supported? That indicates that you believe the client has the right to their own choices.

Ms. Shaffer: You said that with the service plans we want to make sure we have wellness goals instead of intervention goals.

Mr. Diksa: Ask people to write down how they spend their time on weekends and then how ideally they would like it to be.

Ms. Knight: People fight so hard to get to these different levels till they get to the wellness level, but then you have the public knocking them right back down. Even though the ADA says there should be equal accommodations for the mentally ill, in practice that often doesn't happen.

Dr. Diksa: There's a program called Windmills that helps employers with stigma. But you also need to include employers and Chamber of Commerce in your stakeholder group.

Supervisor Dufty: It's tough for me to make these meetings, because I juggle a lot with my schedule. I apologize that I can't spent more time with you.

I do agree that Prop 63 is the major priority for the Board. And in a year when the City does not have much money, to be able to rethink services is a unique opportunity. I am holding a hearing at the City Services Committee, and am asking Barbara Garcia to come and detail the planning process for Prop 63.

And I do agree that more than one MHB member should be on the planning committee. I think the MHB should be somewhat strategic. I think the Board should not have to plan the system, that's the job of the Department. But this Board needs to provide

perspective that the department staff don't always see. We should be strategic instead of trying to duplicate the Department's work.

I think the MHB will be the key first step in getting approval from the Board of Supervisors. I've appreciated coming to Board meetings and what I've learned and that I've gotten to know key people like Bob Cabaj and Barbara Garcia.

And please feel free to call on me to help you, like if you need a meeting with the Mayor.

At a time when there is a lot of hopelessness, this is a opportunity to do some new things.

The hearing would be a platform to educate the public. We have a hearing on Thursday evening on the health crisis in Hunters Point, for example. This might help educate the public about the planning process for Prop 63.

Dr. Turner: Thank you Bevan, we really do feel your support. And we appreciate what you do.

Ms. Kellum-King: I would like to hear about Bevan's view of meeting in City Hall.

Supervisor Dufty: I don't know if City Hall in San Francisco is so intimidating that people wouldn't come. People are used to coming out to hearings there. I like to think of it as the People's Hall. Many hearings and meetings are televised from City Hall. You might structure a couple meetings on Prop 63 to be televised. It would help put the MHB on the map and educate the public about Prop 63. Those televised meetings can then be linked to from your website.

Ms. Wilson: I want to see diversity in whatever we develop. You cannot have a staff or a program and it's all one culture, or just one emphasis. It's just gotta be everybody. Everybody has to be in there. This city is diverse. They put that word out there, but do we represent it in practice?

Dr. Turner: Yes, we need to have diversity in the stakeholders, in the speakers we invite, in committee members.

Ms. Wilson: We can use this Board as an example of diversity.

Dr.. Turner: Ed, we so appreciate you being here today. It was so informative, and I like your style of letting us interrupt you.

Dr. Diksa: One of the reasons I love my job is that every one of you believes in this issue strongly enough to get in trouble over it. It's really enjoyable for me to see your passion.

How do you use your passion but without turning it off in someone else? You are passionate in a way that you also support each other's passionate energy. You are all moving forward together. As long as you respect each other and support each other, I think you're going to go a long way.

Here's a motto to consider: Be patient, be kind, and stick like a leech.

Sometimes things get more divisive when you have more money to spend than when there are cuts. So be patient, be kind, and stick like a leech.

BREAK

Dr. Turner: In closing, I wanted us to get a few key wisdoms and points. And we also need to think about our agenda for the next meeting. We'll need to confirm the date of that meeting via e-mail.

Ms. Knight: This is a chance for the MHB to get involved in Prop 63 and we need to incorporate the administrators, because we don't want to alienate them. We need a CBHS administrator to stay at the whole meeting. It's not enough for them to make their report and then leave.

Dr. Turner: What I've heard today is that our role is one of strategy. That we are not duplicating what CBHS is doing. We strategize and communicate fully with the administrators about implementing Prop 63.

Mr. Luebkeman: We want the CBHS administrator at our meeting to be able to take back what they hear to the rest of the administrators. I'm not sure if they view their role as absorbing the ideas of the MHB and taking them back to the other administrators.

Mr. Medema: What Bevan said about not re-inventing the wheel is important. But that doesn't mean that we don't disagree with CBHS if we see things differently.

With Prop 63 we have this monumental task ahead of us, and everything we read or see or hear about Prop 63 say this is a revolutionary way of dealing with mental health in the state of California. This is the time for this Board to step up and become the player that this Board can become. We can increase our visibility and our strength and increase our meaning.

Dr. Turner: I'm hearing this from everybody, that people like the empowerment, that we are insisting on the empowerment. That we have some ways of making that happen proactively instead of just reacting.

Mr. Medema: We need to be looking toward the future, we can't be playing catch up. We need to be players who are looking at what's happening next month and six months from now. We need to be future-based and not past-based.

Ms. Walker: You may have power, but if you don't use it, you lose it. I hope at our next meeting, that everybody who has a bee in their bonnet comes and presents it.

Mr. Luebkeman: Is next year going to be all about Prop 63? Will there be no opportunities for other input or programs? I know 63 needs to be the priority for the year, but what's happening for other citizens of San Francisco.,

Dr. Turner: We were thinking about Prop 63 as our main focus and then we'd use that as the context for looking at other innovative programs.

Mr. Luebkeman: Ed said our focus is the entire city, not just MediCal. We've never had a presentation about the non-City delivery systems and whether people are getting what they need.

Ms. Shaffer: We need to get data about outcomes.

Mr. Medema: As we work on Prop 63, we will find issues that we need to address.

Mr. Douglas: I think Joel has a good point, because what the private providers don't provide, the City has to provide. Maybe after July when the major share of our Prop 63 work is done, we could focus on these other things.

Ms. Walker: I would suggest using the January meeting as a planning meeting for Prop 63 as well as the special meeting in December.

Mr. Douglas: Perhaps we could have a speaker from the administration and perhaps the MHA about Prop 63.

Ms. Shaffer: Can we accurately say what our community needs for mental health services? Knowing that is one of our mandates. That's a question for Prop 63 as well.

Mr. Medema: We need to be at the stakeholder meetings to hear what the community is saying about what the needs are.

Ms. Kellum-King: I live in Visitacion Valley, other people live in the Bay View Hunter's Point, and almost all of us are suffering from PTSD. There are so many shootings, and not all of them are in the press. How do we address those parents who are suffering? My son was beaten and he'll never be the same. He says he walks on eggshells when he goes out. I go to fewer meetings and I got off Boards because my neighborhood is not safe.

Dr. Turner: So we are talking about whole communities that are traumatized. How do we advocate for what we need in those communities? And also prevention. That's the revolutionary part of Prop 63. And what about our concern about kids going to school with weapons because they don't feel safe? Do we have enough resources for the School Resource Officers?

Ms. Kellum-King: Some of the SRO's are getting kicked out of schools because the principals don't like their strong personalities.

Ms. Walker: It's our job when we see a whole community suffering to see how Proposition 63 can affect that. We have to be able to suggest a solution.

Mr. Douglas: Having gotten mugged last night, this PTSD thing couldn't be any more real to me than it is today. Certainly the Tenderloin community where I live has more

than its share of problems. We have police officers running around like out of the movies. I think the way to ask mental health to deal with this is by running groups.

Ms. Shaffer: It doesn't sound like **Post** Traumatic Stress Disorder. It feels like **Perpetual** Traumatic Stress Disorder.

Dr. Turner: What about our agenda for the December meeting.?

Mr. Douglas: We need to focus on organizing ourselves.

Ms. Walker: Each of us who has an idea, can bring both what the problem is and what they want Prop 63 to say about the problem.

Mr. Medema: The priority thing for that day is I want to hear from DPH about when those meetings are taking place.

Dr. Turner: One thing we can do is ask Barbara Garcia for any information we can get from her.

Ms. Walker: If I may make myself more clear, I would say that the meeting in December should be to figure out what our role is and to do what we need to in order to know the specific things that we want to do.

Mr. Medema: I'd like to see us bring to our December meeting a letter that could be sent out that day to Barbara and Bob about the stakeholders, and the people we want to see on that stakeholder group.

Mr. Douglas: I'm thinking that we should also talk about the budget for this year, because the budget cuts are before the Board of Supervisors now. I think we need to deal with this year's cuts.

Ms. Knight: A lot of things have already happened, they've laid off a lot of administrative secretarial staff and a lot of minority department heads have been laid off. Staff have been reassigned because of integration. This has an impact on the staffing under Prop 63.

Mr. Medema: As the MHB, we can ask Barbara Garcia for anything anytime, whether or not she gives it to us.

Ms. Brooke: What's the decision about the January MHB meeting?

Mr. Medema: This would be a time when it would be ideal for Chance and I to come before the meeting with recommendations out of the hearing that takes place on December 8th. This is an issue we're passionate about.

Mr. Luebkeman: I think we need to talk about our strategy for getting new Board members on the Board at our January meeting.

Ms. Shaffer: We'll know more at this meeting next week and following the hearing that Bevan will run.

Dr. Turner: I really, really want to thank you all for such a fascinating, interactive, participative day. I'm so looking forward to 2005. I know it's going to be very challenging and exciting year.

There being no further business the meeting was adjourned at 4:15 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: (415) 255-3760
mhb@igc.org
www.sfgov.org/mental_health

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The Mental Health Board meeting scheduled for December 8, 2004, has been CANCELED

The Board will be holding its Annual Retreat on Saturday, December 4, 2004, at the Hotel Nikko, 222 Mason Street, San Francisco, from 9 a.m. to 4 p.m.

No final votes will be taken by the Board at the Retreat. Any proposals or resolutions developed by the Board during the Retreat will be placed on the agenda for public comment and to be voted on at its next regular meeting on **Wednesday, January 12, 2005, at 6:30, at 1380 Howard Street, Room 537.**

An agenda for that meeting will be sent out at the beginning of January.

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